CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INPATIENT HOSPITAL SERVICES

General Information

Patients covered under the Medicaid Program are entitled to have payment made on their behalf for covered inpatient hospital services in a participating hospital subject to the limitations described below.

Inpatient Defined

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

Covered Inpatient Care

Inpatient care is a covered service under the Medicaid Program if it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The service must be consistent with the diagnosis or treatment of the patient's condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury or to the functioning of a malformed body member is not covered.

Inpatient services do not include:

- Behavior modification;
- Remedial education;
- Day care;
- Psychological testing done for any or all of the following purposes: educational diagnosis, school recommendations, institution admission or institutional placement; and
- Alcoholism and drug abuse therapy

Other severity of illness and intensity of service criteria must be met to justify admission and length of stay when covered services are provided.

Claims with an alcohol/drug rehabilitation and detoxification ICD-9 CM procedure code 94.6-94.69 will no longer deny for "services not covered" if there is a preauthorization on file by WVMI. Alcohol and drug rehabilitation and detoxification remain non-covered services under the Virginia Medicaid program. However, the Department of Medical Assistance Services (DMAS) recognizes that medical detoxification is, at times, part of a medically appropriate treatment plan. DMAS will conduct retrospective audits of these authorizations to ensure that the criteria for medical necessity are met.

Admission of MEDALLION Clients

Medicaid enrolled hospitals must obtain authorization from the MEDALLION client's primary care physician (PCP) to admit a client for inpatient care. Without this authorization, reimbursement claims for inpatient services will be denied. This authorization can be obtained from the PCP by calling the telephone number on the client's MEDALLION PCP card. See the billing instructions for the UB-92 HCFA-1450 Universal Claim form (UB-92) in Chapter V regarding recording the Medicaid provider identification number of the PCP in Locator 83Aa. Detailed information on MEDALLION referral requirements can be found in Supplement A of the provider manual.

Inpatient Preauthorization

DMAS has contracted the services of WVMI to provide telephonic preauthorization of all inpatient hospital admissions. This preauthorization began phasing in for hospitals on January 21, 1997, according to the schedule below.

Hospitalization Review Level	Preauthorization Effective for Dates of Service On and After
75th Percentile	February 18, 1997
90th percentile	March 3, 1997
95th Percentile	March 3, 1997
Exempt Status	April 1, 1997

The preauthorization process will be conducted as a telephonic review process. Contact WVMI at the following numbers:

(804) 648-3159	Richmond area
1-(800)-299-9864	All other areas (toll free)

WVMI will accept facsimile requests for planned/scheduled admissions for surgery and Temporary Detention Orders. Use the Virginia Medicaid Utilization Management form to fax these preauthorization requests. (See "Exhibits" at the end of this chapter for a sample of this form.) The fax numbers are

(804) 648-6880	Richmond area
1-888-243-2770	All other areas (toll free)

All admissions must be preauthorized within 24 hours of admission or on the next business day after the admission. The health care provider calling to initiate preauthorization of the admission must provide the recipient's name; the identification number; the admitting physician's name; the primary care physician's name (if applicable); the admission diagnosis and ICD-9-CM diagnosis code(s); the medical indication for hospitalization; and the plan of care. WVMI will apply InterQual ISD-AC criteria or "Medicaid Inpatient Psychiatric Services Criteria" to the medical information provided. If criteria are met for admission and the admission is prior to or on 12/31/1999, an initial length of stay will be assigned at the 25th percentile according to the HCIA Length of Stay by Diagnosis and Procedure, Southern Region. A preauthorization number will also be provided for billing purposes.

Prior to the expiration of the initial assigned length of stay, if the recipient requires continued inpatient hospital care, the health care provider must contact the WVMI review staff to initiate the concurrent review process. The health care provider must be able to provide the WVMI review staff with the recipient's name and Medicaid identification number/preauthorization number and must be prepared to discuss the medical indications and plan of care for continued hospitalization. For those recipients who do not meet InterQual criteria on admission but do meet the criteria later in the hospitalization, the preauthorization must be obtained within one business day of the patient's meeting criteria. The review analyst will apply InterQual ISD-AC criteria or "Medicaid Inpatient Psychiatric Services Criteria" to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the recipient is discharged.

Admissions on or after January 1, 2000, still require preauthorization by WVMI for the admission or at any time the InterQual ISD-AC criteria are met during the hospitalization. WVMI will provide a preauthorization number for the admission date. Under the DRG reimbursement methodology (effective for admissions on or after January 1, 2000), no continued stay reviews will be conducted by WVMI for recipients receiving general acute care services by WVMI. Psychiatric admissions and continued stay reviews will continue to be authorized by WVMI. For those recipients who do not meet InterQual criteria on admission but do meet the criteria later in the hospitalization, the preauthorization must be obtained within one business day of the patient's meeting the criteria.

Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must telephone the WVMI review staff to initiate a retrospective review of the medical indications and plan of care for the hospitalization in question. The review analyst will apply InterQual ISD-AC criteria to the information provided. Psychiatric admissions and lengths of stay will be retrospectively authorized in the same manner using the "Medicaid Inpatient Psychiatric Services Criteria" under "Exhibits" at the end of this chapter. If the hospitalization is found to meet medical necessity criteria for some or all of the stay, a preauthorization number will be assigned and the approved dates of service will be identified.

The hospital must bill the complete dates of service for inpatient services whether or not they have been preauthorized or denied. Non-authorized (denied) inpatient services will not be covered or reimbursed by DMAS. When submitting a bill, the following information must match the preauthorization: the recipient's name, recipient identification

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number, authorized dates of service, and the assigned preauthorization number in Locator 63 of the UB-92 HCFA-1450 Universal Claim form. Regardless of preauthorization, if the invoice reflects a transplant, sterilization, hysterectomy, or abortion ICD-9 CM procedure code, the claim will pend for DMAS manual review. If the required DMAS form is not attached, the claim will be reduced or denied according to DMAS policy. Likewise, if the patient is over the age of 21 years and the preauthorized stay(s) exceeds the 21-day in a 60-day period service limit, the claim will pend for DMAS manual review:

1. For resolution for claims with admission dates prior to or on December 31, 1999 and

2. For all psychiatric hospitalizations.

Any admissions which exceed 21 days in a 60-day period for the same or similar diagnosis will have days reduced or denied.

Preauthorization is not required for normal maternity/newborn inpatient care effective for all claims received on or after December 29, 1997. This includes normal vaginal deliveries, ICD-9-CM procedure code(s) within the following ranges, 72.0-72.9, 73.0-73.09, 73.2-73.22, 73.5-73.99, 75.50-75.69, and 75.8 with a length of stay less than or equal to three days from the date of admission; caesarian section deliveries, ICD-9 CM procedure code range 74.1 through 74.99, with a length of stay less than or equal to five days from the date of admission; and newborns who are in the normal nursery, revenue code 170 or 171, with a length of stay less than or equal to five days from the infant's date of birth. Preauthorization will be required for the entire newborn stay if the infant is in any other nursery setting (i.e., revenue codes 172, 173, 174, 175, or 179) for any part of the stay. WVMI must preauthorize maternity and newborn stays which do not fall within these parameters, and the preauthorization must be on file with DMAS prior to billing for the stay. This requirement for preauthorization remains in effect for those admissions on or after January 1, 2000.

All transplants, with the exception of corneas, require written requests for preauthorization. See "Transplant Surgery" in this chapter for additional information.

To minimize time on the phone when calling for preauthorization, consider the following suggestions. The necessity of these requirements will be deleted for admissions on or after January 1, 2000, except for psychiatric services. The suggestions are:

- Peak hours for telephonic review are between 2:00 and 5:00 P.M. The provider may wish to place the provider preauthorization call earlier in the day.

- Have available all the necessary demographic and clinical information needed in order to obtain the preauthorization. Inadequate clinical information may result in the request being pended for additional information. This requires the provider to call WVMI back with the additional clinical information needed. By being prepared, the provider can avoid this call back.

- Procedures done as an outpatient do not require preauthorization. However, if the patient is subsequently admitted to the hospital due to postoperative complications, the provider must call to have the admission and length of stay preauthorized.

- Medicaid defines "observation beds" as outpatient services and does not require preauthorization.

- No telephone call is necessary if the patient is discharged prior to the date the length of stay assignment ends. However, the provider must call WVMI to extend the length of stay if the patient stays beyond the assigned length of stay. The exception to this is for the adult patient who stays beyond 21 days. The hospital is only responsible for obtaining preauthorization for the first 21 days of inpatient care. For patients under the age of 21, all inpatient days must be preauthorized; an exception is a newborn in the normal nursery or Labor and Delivery admissions, as previously discussed.

- Requests for cosmetic surgery, transplants with the exception of corneal transplants, and procedures on the "Preauthorization by Medical Support Table," must first be sent in writing to the Director of Medical Support at the Department of Medical Assistance Services (see "Exhibits" at the end of this chapter for this table). Once the procedure has been authorized, contact WVMI to obtain authorization if inpatient admission and length of stay are required. Cosmetic surgery performed solely to enhance appearance is not a covered service. Claims submitted must have the letter of authorization from Medical Support attached to the claim at the time of submission or the claim will be denied.

Edits on Inpatient Admissions for Claims Prior to Preauthorization

For dates of service prior to the effective date of preauthorization and on and after September 1, 1995, hospitals must submit documentation of medical justification for:

- Lengths of stay exceeding three days;

- An admission date prior to the date of surgery;

- Weekend admissions (Saturday and Sunday);

- Admissions for which the length of stay exceeds the percentile limits for principal diagnosis;

- Admissions for which the length of stay exceeds the 21-day limit on hospitalizations within a 60-day period for a recipient 21 years of age or older; and

- The requirement for abortion, hysterectomy, and or sterilization form.

Hospitals with Exempt Status for utilization levels are exempt from these documentation requests unless mandated by federal or state regulations.

Reconsideration of a Preauthorization Denial

If an admission or continued stay is denied by the WVMI review analyst and the provider disagrees with the decision, the provider must follow a two-step telephonic reconsideration process. First, the provider may request reconsideration of the denial by the WVMI Utilization Management (UM) Supervisor the WVMI review analyst denies preauthorization. If the UM Supervisor upholds the denial, the provider may request reconsideration by the DMAS physician consultant at the time denial is upheld by the WVMI supervisor.

Following this two-step reconsideration process, the denial of preauthorization for services not yet rendered in an inpatient hospital setting may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered and the issue is whether DMAS will reimburse the provider for the services already provided, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial. Send all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS or WVMI staff will perform annual desk or on-site audits of the hospital's utilization review activities.

Covered Days

DMAS limits coverage for medically necessary inpatient hospital as follows:

- Except as provided below, patients 21 years of age and older who enter acute-care hospitals are limited to 21 days of medically necessary hospitalization within 60 days from the date of the first admission for the same or similar diagnosis (effective for dates of service on or after October 1, 1986).

- Effective with general acute medical/surgical admissions on or after January 1, 2000, there is no longer a 21-day within 60-day limit for these services per admission. The limit of coverage to 21 days within 60 days still applies for psychiatric admissions for individuals over the age of 21. Psychiatric admissions and lengths of stays must be preauthorized by WVMI.

  Physician's Note: Payments for hospital visits are limited to the appropriate number of approved hospital days (effective October 1, 1986).

- Patients under 21 years of age who enter acute-care hospitals are not affected by the limitation on covered hospital services (effective for dates of service on and after October 1, 1986). The program covers their entire length of

medically necessary hospitalization until their 21st birthday. Such coverage is provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Certification of Covered Days

The number of covered days of hospital care shall be determined through periodic certification of the need for care by the attending physician and through the DMAS-approved utilization review plan in effect for each hospital (see Chapter VI).

Coverage of Day of Admission and Day of Discharge

The day of admission is covered as a full day of inpatient care, regardless of the time of admission. The day of discharge is not an authorized day of care by Medicaid and cannot be reimbursed. The midnight-to-midnight method shall be used in reporting days of care.

Coverage of Day of Death

The day of death is the day of discharge.

If an admission was medically necessary and appropriate and there was a reasonable expectation that the patient would remain at least overnight and occupy a bed, the admission shall be authorized as a day of inpatient care, even if the patient is discharged later the same calendar day.

Coverage of Pre-Surgical Days

An inpatient hospital stay before non-emergency surgery cannot precede the admission day unless medically justified. It is expected that the provider will ensure that all pre-surgical services will be rendered in an outpatient setting unless there is medical justification for rendering these services in an inpatient setting.

Late Discharge

Medicaid will not pay for a continued hospital stay if the continued stay is for personal, non-medical reasons, or a patient chooses to continue to occupy the hospital accommodation beyond the checkout time. If the continued stay is caused by the patient's medical condition, the stay beyond the discharge hour is covered by Medicaid.

Leave of Absence

The day on which the patient begins a leave of absence or furlough is treated as a day of discharge and is not considered a day of inpatient care. The day the patient returns from a leave of absence or furlough is treated as a day of admission and is considered a day of inpatient care if the patient returns to the hospital by midnight.

It should be noted that leaves of absence are permitted for therapeutic purposes only. The objectives of the leave of absence must be documented prior to the leave, and the goals

obtained and an evaluation of the leave must be documented upon the patient's return. Leaves of absence for procedures which are not available at the treating facility (for example, CAT scan, or renal dialysis) are considered medical therapeutic leaves.

Non-Covered Days

Hospitals must bill for all days and charges even if a portion of an inpatient stay is not covered by Medicaid because this may affect the DRG part of cost settlement and reimbursement effective with admissions on or after July 1, 1996.

Ineligible Days

Recipients who become eligible or lose their eligibility for Medicaid during a hospitalization will still need to have the complete hospitalization submitted to Medicaid for reimbursement. Medicaid will reimburse the number of days the recipient is eligible for Medicaid for admissions on or prior to December 31, 1999. With admissions on or after January 1, 2000, reimbursement will be based on the DRG payment methodology; and therefore, the entire hospitalization will be paid as long as the recipient is eligible for Medicaid for a portion of the hospital stay.

Accommodations

Accommodations refers to the room in which the patient is housed while a hospital inpatient. Medicaid will pay for the reasonable cost of semi-private or ward accommodations (two or more patients).

Private Room Accommodations

Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semi-private only when such accommodations are medically necessary.

Private rooms are considered medically necessary when the patient's condition requires isolation for the patient's health or for that of others. Physician certification of the medical necessity for the private room must be on file prior to discharge. Reimbursement will also be provided for care in special units, such as intensive care and coronary care, if the care is medically necessary. If private room accommodations have been furnished the patient but are not medically necessary, reimbursement shall be provided at the most prevalent semi-private rate. The most prevalent semi-private rate is the rate which applies to the greatest number of semi-private beds.

Private room accommodations furnished at the request of the patient are **not covered** by DMAS. Billing to DMAS must be at the most prevalent semi-private rate. Providers are not allowed to bill or collect from the patient or family the difference in charges between private and semi-private accommodations.

Other Services

Nursing Services

Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered. These costs are covered on a reasonable cost basis as a part of inpatient routine care provided under accommodations.

Not covered are the services of a private-duty nurse or other private-duty attendants, the patient's personal physician, and other practitioners not employed by the hospital. Physician visits and or services to inpatients must be billed separately using the HCFA-1500 Universal Claim form.

Physician Assistants

Physician assistants are not covered as a stand-alone provider. The services a physician assistant provides cannot be billed by the physician who supervises them unless the physician has provided direct and personal supervision. This is defined such that the physician must be available for immediate consultations, treatment or emergency care should they be needed. The physician does not have to be in the room or perform a physical examination of the recipient in order to bill for the services of the physician assistant. However, the recipient's medical record must contain documentation that the physician reviewed and concurs with the findings, diagnosis and any treatment provided and/or recommended by the physician assistant for reimbursement.

The medical services provided by an intern or resident-in-training under an "approved teaching program" of a hospital are covered.

An "approved teaching program" means a program approved by the Council on Medical Education of the American Medical Association.

The services performed by interns and residents are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are **not** reimbursable on a fee-for-service basis as physicians' services.

Ancillary Services

Drugs and Biologicals

Drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

Blood and Blood Components

Whole blood and equivalent quantities of packed red blood cells are covered by Medicaid when not available from other sources.

Other components of whole blood (e.g., plasma, gamma globulin, etc.) are covered biologicals.

Supplies, Appliances, and Equipment

Supplies, appliances, and equipment ordinarily furnished by the hospital for the care and treatment of the recipient solely during his or her inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the inpatient stay are covered even though they leave the hospital with the patient when he or she is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, artificial limbs, and tracheostomy or drainage tubes that are temporarily installed in or attached to the patient's body while he or she is receiving treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Supplies, appliances, and equipment furnished to an inpatient recipient for use outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital and which is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

Physical Therapist Services

To be reimbursable by DMAS, inpatient and outpatient physical therapy must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment regimen designed by the physician after any needed consultation with the licensed physical therapist;
- The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the judgment and skills of a qualified physical therapist are required;
- The services must, in fact, be performed by or under the direct supervision of a licensed physical therapist (i.e., a licensed physical therapist must be present on the premises when services are rendered);
- The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; and
- The services must be reasonable and necessary for the treatment of the patient's condition.

Many hospital inpatients who do not require physical therapy services, as defined above, do require services involving physical modalities and procedures which are routine, in the sense that they can be rendered by supportive personnel (e.g., aides or nursing personnel without the supervision of a licensed physical therapist). Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general modification), are never reimbursable as physical therapy. However, since they constitute an essential and integral part of good patient care, the cost of such services may be included in the routine allowable costs of the institution.

Since DMAS' definition of reimbursable physical therapy is essentially the same as that for Medicare, the same documentation required for Medicare is accepted by DMAS.

Speech and Hearing Services

Certified hospitals which have speech and hearing departments or appropriate arrangements with qualified speech therapists and audiologists (including independent speech and hearing centers) may be reimbursed by Medicaid on a cost basis for inpatient and outpatient speech and hearing services ordered by a physician. Reimbursement is limited to those services related to a medical diagnosis, such as stroke or post-laryngectomy. Long-term speech therapy, such as may be required for a child with cerebral palsy, is not covered under Medicaid during an inpatient hospital stay.

Diagnostic testing performed by a qualified audiologist is covered when a physician orders such testing for the purpose of mandated initial newborn hearing screens, or obtaining additional information necessary for his or her evaluation of the need for, or appropriate type of, medical or surgical treatment for a hearing problem. For example, diagnostic services performed by a qualified audiologist to measure a hearing loss or to identify the factors responsible for the loss are covered when such services are necessary to enable the physician to determine whether otologic surgery is indicated.

For the purpose of Medicaid, a qualified audiologist or speech therapist is one who has been granted a Certificate of Clinical Competence in the appropriate area by the American Speech and Hearing Association or who has completed the academic and practicum requirements for certification and is in the process of accumulating the necessary supervised work experience required for certification.

Other Diagnostic or Therapeutic Items or Services

Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed above as covered inpatient hospital services. With respect to items that leave the hospital with the patient upon discharge (such as splints or casts), the rules for determining whether the item is covered are the same as the rules set forth for "Supplies, Appliances, and Equipment" on page 10 of this chapter.

When a psychologist or respiratory or physical therapist is a salaried member of the staff of a hospital, the individual's diagnostic or therapeutic services to inpatients of that hospital

are covered on a reasonable cost basis in the same manner as the services of other non-physician hospital employees.

Psychiatric Hospital Services

Short-Term Inpatient Services

Short-term inpatient psychiatric services are covered in general hospitals when certified by the hospital utilization review committee and preauthorized by WVMI as outlined earlier in this chapter. These committees are charged with the responsibility of determining the level of care that best meets the patients' medical needs. These committees should be reasonable in their determinations, should review the patients' needs as they would any other illness, and should, within a reasonable time, transfer these patients to a lower level of care or to a suitable long-term facility.

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Long-Term Services

Long-term psychiatric and tuberculosis services are covered only for individuals 65 years of age or over and only in facilities for mental diseases that have been appropriately licensed or certified, or both, and enrolled as a provider with DMAS.

Inpatient Psychiatric Services for Recipients Under Age 21 Through the EPSDT Program at Free-Standing Psychiatric Facilities

Medicaid will pay for inpatient psychiatric services for individuals under age 21 who have been identified by a physician as having a condition of mental illness which can be ameliorated or corrected through inpatient psychiatric services. Inpatient psychiatric services are not covered through the *State Plan for Medical Assistance*, but are available only for those individuals under the age of 21 whose needs have been identified through the EPSDT Program. Requests for authorization for admission must be submitted by telephone to WVMI, the DMAS prior authorization contractor, as described in the *Psychiatric Services Manual*. DMAS pays an all-inclusive rate. However, the professional component for the psychiatric care may be billed separately.

Inpatient Rehabilitation Services

Medicaid covers inpatient rehabilitation services in facilities that are certified as rehabilitative hospitals or rehabilitation units of a general acute care hospital. The facility must also have a current provider agreement for rehabilitation services with DMAS. Refer to the *Rehabilitation Manual* issued by DMAS for criteria on covered services and the prior authorization requirements.

Transplant Surgery

Transplant services which are covered when medically necessary and are not experimental or investigational are: kidney and corneal transplants without age limits (effective September 7, 1989); heart, lung, and liver transplants without age limits (effective July 1, 2000); coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer (effective July 1, 1997), leukemia (effective July 1, 1999), or myeloma (effective July 1, 2000); under EPSDT, any other medically necessary transplant procedures that are not experimental or investigational are limited to persons under the age of 21 (effective July 19, 1993).

In addition, specific criteria issued by Medicaid concerning patient and facility selection must be followed for all transplant services. The treating facility and transplant staff must be recognized by Virginia Medicaid as being capable of providing high-quality care in the performance of the requested transplant, and the patient must be considered as acceptable for coverage.

All transplants except (cornea transplants) require prior written authorization by the Medical Support Unit of DMAS and must have the admission and length of stay for inpatient services authorized on the preauthorization file by WVMI. Admissions on or after January 1, 2000, will only need the admission authorized by WVMI.

The following criteria must be followed for patient and facility selection for all transplants except kidney, bone marrow (for diagnosis of lymphoma, breast cancer, or leukemia), and cornea transplants.

I. Patient Selection Criteria (See 12 VAC 30-50-360.)

A. The following general conditions must be met:

1. Coverage will not be provided for investigational or experimental procedures;

2. There must be no available effective, alternative medical or surgical therapies with outcomes that are at least comparable;

3. The transplant procedure and use of the procedure in treatment of the specific condition for which it is proposed must be clearly demonstrated to be medically effective; and

4. Prior authorization by DMAS is required. The prior authorization request must contain the information and documentation as required by DMAS.

B. The following specific conditions regarding patient selection (if required for a specific transplant) must be met:

The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. The transplant team or program must review the recipient's medical condition and, based upon the transplant center's criteria, determine that the recipient is an appropriate candidate for the transplant procedure.

Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's selection criteria, based upon review by DMAS of the information submitted by the transplant team or center.

Patient selection criteria used by the transplant center must include, at a minimum, the following:

a. Current medical therapy has failed, and the patient has failed to respond to appropriate therapeutic management;

b. The patient is not in an irreversible terminal state; and

c. The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

II. Facility Selection Criteria Start

A. The following general conditions must be met:

1. Procedures must be performed out of state only when the authorized transplant cannot be performed in the Commonwealth of Virginia (the Commonwealth) because the services are not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period; and

2. Criteria applicable to transplant services and facilities in the Commonwealth also apply to out-of-state transplant services and facilities.

B. To qualify for coverage, the facility must meet, at a minimum, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific disorder necessitating the transplant procedure;

2. The transplant surgeon(s) has been trained in the specific transplant technique at an institution with a well-established program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, and immunological and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. The faculty must have current full membership in the United Network for Organ Sharing for facilities where solid organ transplants are performed;

8. Membership exists in a recognized bone marrow registry program for bone marrow transplant programs;

9. The transplant facility or center can demonstrate satisfactory transplant outcomes for the procedure being considered;

10. Transplant volume at the facility is consistent with maintaining quality services; and

11. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

To obtain additional information, contact:

Director of Medical Support
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

804-786-8056
FAX 804 786-0414

Reimbursement

Reimbursement for covered liver, heart, lung, and bone marrow transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of: (a) a prospectively determined, procedure-specific flat fee determined by the agency, or (b) a prospectively determined, procedure-specific percentage of usual and customary charges or actual charges. The reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The reimbursement does not include pre- and post-hospitalization for the transplant procedure, pre-transplant evaluation, or organ search. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. All claims for the transplant hospitalization must be submitted to:

Manager, Payment Processing Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Maternity Care

DMAS covers maternity inpatient hospital charges as follows (effective July 1, 1996). DMAS will cover the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity or prior authorization. DMAS will cover the day of delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims that exceed the above number of days must be medically justified, and the complete stay for admission prior to or on December 31, 1999, must be prior authorized by WVMI. Admissions must have the admission authorized for hospitalizations that exceed the above number of days for admissions on or after January 1, 2000.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, DMAS will cover an early discharge follow-up visit as recommended by the physician, in accordance with the following guidelines. The mother and newborn must both meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge visit does not affect or apply to any usual postpartum or sick/well baby care; it applies only to an early discharge. The criteria for an early discharge follow below.

CRITERIA FOR EARLY DISCHARGE OF MOTHER AND INFANT

MOTHER:

Uncomplicated Vaginal, Full Term Delivery Following a Normal Antepartum Course

Postpartum observation has sufficiently documented a stable course, including the following observations:

- Uterine fundus is firm, bleeding (lochia) is controlled, of normal amount and color;
- Hemoglobin is greater than 8, hematocrit is greater than or equal to 24, and estimated blood loss is not greater than 500 cc. or blood loss does not result in the patient's being symptomatic for anemia (i.e., lightheadedness, syncope, tachycardia, or shortness of breath);
- Episiotomy/repaired laceration is not inflamed, and there is no evidence of infection or hematoma;
- Tolerating prescribed diet post delivery;
- Voiding without difficulty and passing flatus. Bowel sounds present; and
- If not previously obtained, ABO and Rh typing must be done and, if indicated, the appropriate amount of Rho(D) immunoglobin must be administered.

INFANT:

The newborn must be deemed normal by physical examination and stable meeting the following criteria:

- Term delivery and weight are considered normal;
- Infant is able to maintain a stable body temperature under normal conditions;
- Infant is able to take and tolerate feedings by mouth and demonstrates normal sucking and swallowing reflexes;
- Laboratory data must be reviewed to include:

a. Maternal testing for syphilis and hepatitis B surface antigen;

b. Cord or infant blood type and direct Coombs test (if the mother is Rho(D) negative, or is type O, or if screening has not been performed for maternal antibodies);

c. Hemoglobin or hematocrit and blood glucose determinations, as clinically indicated; and

d. Any screening tests required by law; and

e. Initial hepatitis B vaccine must have been administered.

MOTHER AND INFANT:

- Family members or other support person(s) must be available to the mother for the first few days following discharge;

- The mother has demonstrated the ability to care for her infant including feeding, bathing, cord care, diapering, and body temperature assessment and measurement with a thermometer;

- The mother or caretaker has been taught basic assessment skills including neonatal well-being and recognition of illness. She verbalizes understanding of possible complications and has been instructed to notify the appropriate practitioner as necessary;

- A physician-directed source of continuing medical care for both mother and baby must be identified and arrangements made for the baby to be examined within 48 hours of discharge; and

- The follow-up visit must be provided as directed by a physician. The provider of the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge. Minimum requirements for the follow-up visit are in the *Physician Manual* issued by DMAS.

<u>Newborn Infant Care</u>

Virginia Medicaid provides coverage for the high-risk infant who requires medically necessary stays in a hospital's newborn nursery beyond the mother's discharge or in an approved neonatal intensive care unit (NICU). Qualification procedures for hospitals desiring recognition as an approved NICU provider are set forth in Chapter VII.

Refer to Chapter V of this manual for the required billing procedures for newborn infant care and NICU care.

Abortions, Hysterectomies, and Sterilizations

The Department of Medical Assistance Services, in its coverage of abortions, hysterectomies, and sterilization procedures, must meet strict federal and state requirements. The consent and certification requirements for these procedures are discussed in Chapter VI of this manual.

Services to Promote Fertility

Virginia Medicaid does not cover services to promote fertility (effective with dates of service on or after April 1, 1993). Medicaid will not pay for the medical procedure if its only goal is to promote fertility. If there is a disease of the reproductive system that requires treatment to maintain overall health, it will be covered. Providers must submit sufficient documentation to substantiate the medical necessity of the procedure. The following surgical procedures are no longer covered by Medicaid:

- Repairs of spermatic cord and epididymis;
- Transplantation of spermatic cord;
- Other repair of spermatic cord and epididymis;
- Repair of vas deferens and epididymis;
- Reconstruction of surgically divided vas deferens;
- Epididymovasostomy;
- Removal of ligature from vas deferens;
- Other repair of vas deferens and epididymis;
- Repair of fallopian tube;
- Simple suture of fallopian tube;
- Salpingo – oophorostomy;
- Salpingo – salpingostomy;
- Salpingo – uterostomy;
- Other repair of fallopian tube; and
- Implantation or replacement of prosthesis of fallopian tube.

Contraceptive Capsules (Norplant)

Virginia Medicaid will reimburse its usual allowance for the insertion, removal, or removal with reinsertion of implanted contraceptive capsules (Norplant) regardless of any other services performed. When a woman has Norplant implants inserted and paid for by Medicaid, she may no longer be eligible for Medicaid when it is time to remove the implants. There is no process that would allow Medicaid reimbursement for the removal of the implants when the recipient is not Medicaid-eligible on the date of removal.

Cosmetic Surgery

Cosmetic surgery is not covered when provided solely for the purpose of improving appearance. The exclusion of cosmetic surgery does not apply to congenital deformities or to deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery. Prior written authorization must be obtained from Medicaid. All requests for prior authorization must be in writing to:

Director of Medical Support
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization letter must be attached to the invoice to obtain payment.

Elective Surgery

The Virginia Medicaid Program defines elective surgery as surgery not medically necessary to restore or materially improve a body function. This includes surgery for conditions such as morbid obesity, virginal breast hypertrophy, and procedures that might be considered cosmetic. For coverage of these procedures, prior written authorization must be obtained from Medicaid. These requests must be sent to:

Director of Medical Support
Division of Program Operations
Department of Medical Assistance Services
1600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the approval letter must be attached to the invoice for payment to occur.

OUTPATIENT HOSPITAL SERVICES

Outpatient Defined

When a hospital uses the category "day patient" (i.e., an individual who received hospital services during the day and is not expected to be lodged in the hospital at midnight), the individual is classified as an outpatient.

Outpatient Hospital Services

Services furnished by or under the direction of a physician in the hospital's outpatient department or clinic are covered by Medicaid, and DMAS reimburses allowable costs.

- Covered diagnostic services include: hematology chemistry, diagnostic x-rays, isotope studies, EKG, pulmonary function studies, thyroid function test, etc.

- Other outpatient services include: use of emergency room, observation beds, medical supplies, dressings, oxygen, ointments, splints, special therapy treatments, etc.

DMAS will accept outpatient billings for the medically necessary ancillary services that would have been rendered on an outpatient basis but are provided during a denied inpatient stay. Outpatient billings are limited to those ancillary services performed within the first three days of hospitalization for any inpatient hospital denials.

Observation Beds

Observation services are those services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

DMAS will pay for observation bed services when billed on an outpatient invoice under the following conditions:

- Observation bed services are covered if they are reasonable and necessary to evaluate a medical condition to determine the appropriate level of treatment.

- Non-routine observation for underlying medical complication after surgery or diagnostic services is covered. Medical documentation of the complication is required.

- Services are billed as outpatient status. A hospital may bill for observation bed services for up to 23 hours. A patient stay of 24 hours or more will require inpatient precertification where applicable.

- When inpatient admission is required following observation services, observation charges will be combined with the appropriate inpatient admission and shown on the inpatient bill. Observation bed charges and inpatient hospital charges will not be reimbursed for the same day.

The following services are **not** considered observation bed services and, therefore, are **not** covered:

- Services which are not reasonable or necessary for the diagnosis or treatment of the patient, but are provided for the convenience of the patient or physician.
- Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services. For example, services for routine post-operative monitoring during a normal recovery period (4-6 hours) would not be covered.
- Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which are managed by a physician other than the original emergency physician.
- Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

Services for Medallion Clients

Medicaid-enrolled hospitals must obtain authorization from the MEDALLION client's primary care physician (PCP) to perform outpatient services. Without this authorization, reimbursement claims for outpatient services (other than emergency services) will be denied. This authorization can be obtained from the PCP by calling the telephone number on the client's MEDALLION identification card. See the billing instructions for the UB-92 in Chapter V regarding recording the Medicaid provider identification number of the PCP in Locator 83Aa. Detailed information on MEDALLION referral requirements can be found in Supplement A of this manual.

Admission Certification and Request for Extension for Therapies
[Effective Date: July 1, 1992]

Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals shall include authorization for up to 24 visits per rehabilitative service annually. Limits are per recipient, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30 for each recipient. The provider must maintain documentation to justify the need for services.

NOTE: A visit is defined as the duration of time that a rehabilitation therapist or other health worker is with a client to provide covered services prescribed by a physician**.** Visits are not defined in measurements or increments of time. The furnishing of any services by a particular health worker on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services in the home on the same day, this constitutes two visits. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy sessions in the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Preauthorization is required for outpatient rehabilitation visits in excess of 24. The option of mailing in a DMAS-351 with attached documentation to request preauthorization is not available (beginning with dates of service on or after July 1, 1998). Preauthorization may be obtained only by calling the WVMI at (800) 299-9864 or (804) 648-3159 prior to the completion of the 24th visit. WVMI may request that certain documentation or an entire request be faxed. Telephonic preauthorization must be obtained prior to rendering services. When preauthorization is requested, WVMI will inform the provider of the status of the request (approve, deny, pend, reject). If the request is approved, WVMI will indicate the amount of time approved. If treatment is needed beyond this time frame, the provider must call and request preauthorization prior to the end of the previously approved time period. In the event that treatment has continued with a lapse in authorizations, authorization may begin on the day it is requested if the criteria are met. Requests submitted in writing for preauthorization will be rejected (effective for dates of services on or after July 1, 1998), and the provider will receive a notice reminding him or her of the telephonic preauthorization process. Services provided without preauthorization will not be reimbursed.

The following codes are to be used when requesting rehabilitation therapy beyond the 24 visits a year:

HCPCS Code	Description
Z9471	Physical Therapy, Follow-Up Visit
Z9473	Physical Therapy, Group Session
Z9474	Physical Therapy Evaluation/Re-Evaluation
Z9481	Occupational Therapy, Follow-up Visit
Z9483	Occupational Therapy, Group Session
Z9484	Occupational Therapy Evaluation/Re-Evaluation
Z9491	Speech/language, Follow-Up Visit
Z9492	Speech/language, Group Session
Z9493	Physical/language Evaluation/Re-Evaluation

WVMI will apply InterQual ISD criteria (beginning with dates of service on or after October 1, 1997). The WVMI review staff will approve a time period for services if the InterQual criteria are met. Prior to the expiration of this assigned time period, if the recipient requires continued services, the provider must contact the WVMI review staff to initiate the concurrent review process. The WVMI review staff will again apply the InterQual criteria and, if the criteria are met, will approve an additional time period. Concurrent review will continue in the same manner until the recipient is discharged or no longer meets the criteria.

The only exception to telephonic preauthorization is in cases of retroactive eligibility. The provider may request retroactive authorization in these cases either telephonically or in writing.

Approval of the prior authorization request is approval of medical necessity, not claim payment.

Outpatient Psychiatric and Psychological Services

Psychiatric services are limited to an initial 26 sessions in the first year of treatment, with one possible extension of 26 sessions when preauthorized during the first year of treatment. These initial 26 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is the possibility of an additional 26 sessions in subsequent years when authorized. For further information and specific details, refer to the *Psychiatric Services Manual* issued by DMAS.

GUIDELINES FOR DETERMINING EMERGENCY STATUS FOR PENDED EMERGENCY ROOM CLAIM

The following guidelines will be applied either individually or in combination to determine payment for medical services provided in the Outpatient Hospital Emergency Room setting for Virginia Medicaid recipients. Flexibility with individual patient status and conditions are taken into consideration in the use of these guidelines.

General Information:

The Department of Medical Assistance Services uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

Direct physical attendance by a physician is required in an "emergency" situation. If the physician has not made entries other than his or her signature and diagnosis on the medical record and no documentation is noted that he or she examined the recipient, the visit will

not be considered an emergency. The attendance of a physician assistant does not substitute for the attendance of a physician.

Telephone and/or standing orders do not support emergency treatment.

Emergency room claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements. Hospitals and physicians should insure that the documentation to support the medical necessity for the emergency visit is complete and legible.

Emergency Situations:

- Initial treatment following a recent injury. "Recent" is defined as having occurred less than 48 hours prior to the visit.
- An injury sustained over 48 hours prior to the visit and the symptoms have deteriorated to the point of requiring medical treatment for stabilization.

  Note: Minor injuries requiring only simple first aid that can be done in the home such as cleansing and bandaging an abrasion, are not considered emergencies. A secondary diagnosis such as Diabetes Mellitus may support the emergent need if substantiated.
- Initial treatment for medical/surgical emergencies, including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered "life-threatening."
- Visit in which the recipient's condition requires immediate hospital admission or transfer to another facility for further treatment or visit.
- Motor Vehicle Accident (MVA) within 48 hours.
- Physical abuse (suspected or confirmed) within 48 hours.
- Acute vital sign changes including, but not limited to, the following:

  Adult:

  Temperature of 103° F or higher
  Pulse rate below 40/minute
  Pulse rate above 140/minute
  Respiratory rate below 10/minute
  Respiratory rate above 30/ minute
  Systolic blood pressure below 90mm Hg
  Systolic blood pressure above 200mm Hg
  Diastolic blood pressure below 40mm Hg
  Diastolic blood pressure above 120mm Hg

Pediatric**:**

Temperature of 102° F or higher
Pulse rate above 180/minute for patients under 3 months of age
Pulse rate above 160/minute in patients over 3 months of age
Pulse rate below 70/minute in patients under 3 months of age
Pulse rate below 50/minute in patients over 3 months of age
Respiratory rate above 40/minute in patients under 1 year of age
Respiratory rate above 30/minute in patients over 1 year of age
Systolic blood pressure below 65mm Hg in patients 6 months and under

Systolic blood pressure below 80mm Hg in patients 6-12 months of age
Systolic blood pressure above 100mm Hg in patients 0-7 years of age
Systolic blood pressure above 120mm Hg in patients 7-10 years of age
Systolic blood pressure above 140mm Hg in patients 10 years and older

Diastolic blood pressure above 90mm Hg in all pediatric patients
Diastolic blood pressure below 40mm Hg in all pediatric patients

- Use of IV fluids for hydration purposes.

Non-Emergency Conditions (unless the criteria described below have been met):

Depression/Anxiety: Documentation must clearly indicate that the recipient is an immediate danger to self or others.

Otitis Media – not an emergency unless one or more of the following is noted:

- The tympanic membrane is ruptured.
- There is drainage from the ear(s).
- A fever is documented while in the emergency room:

  Children: Temperature of 102°F or above rectally
  Adult: Temperature of 103°F or above orally

- The recipient is age 2 or under and is crying inconsolably.
- The physician's examination documents the presence of acute otitis media, and there is no access to a physician's office due to being after office hours or on a holiday or a weekend.

Seizures – not an emergency unless:

- The condition was previously undiagnosed, and the visit is immediately following or during a seizure.
- A secondary disorder/diagnosis exists (i.e., hypoglycemia, infection)
- The recipient is 12 years of age or younger.
- Accompanied to the ER by a law enforcement officer and the condition was unknown.
- The recipient is in status epilepticus.
- The recipient is in an epileptic state aggravated by alcohol or drug ingestion

Non-Emergency Situations:

- Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures or treatments, such as drawing blood for lab work.
- The recipient had previously been in the same or different emergency room or in a physician's office for the same condition without worsening signs or symptoms of the condition.
- Scheduled visits to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion.
- Visits made to receive a "tetanus" injection in the absence of other emergency conditions.
- Visits made to obtain medications in the absence of other emergency conditions.
- The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition.
- Medical Clearance/Screenings for Psychological or Temporary Detention Order admissions.

Emergency Room Services (Except for Recipients in the Client Medical Management Program) [Effective Date: July 1, 1991]

Reimbursement for emergency room services for Medicaid recipients (not enrolled under the Client Medical Management Program) will be automatically paid if the principal diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD-9 CM Code (see "Exhibits" at the end of this chapter for this list). Claims for emergency services with the principal diagnosis on Diagnoses to Pend for Review By ICD-9 CM Code will pend for review of the necessary documentation supporting the need for emergency services. (See "Exhibits" at the end of this chapter for this list.) Effective with emergency room claims with dates of service on or after June 1, 2001, the Admitting (presenting signs/symptoms) diagnosis will be utilized to determine the pay or pend status of the claim. All claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements.

Effective with claims with dates of services on or after June 1, 2001, all emergency room claims will either be paid for emergency services or pend for DMAS review to determine the emergency situation warranting care. DMAS will pay an all-inclusive fee of $30.00 to the hospital for those claims found not in compliance for emergency room services. All-inclusive is defined as all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

Laboratory services will continue to be reimbursed under the existing system of rates. Claims identified as emergencies will also be reimbursed under existing rates.

The ordering and interpretation of appropriate diagnostic tests are considered part of the payment to the physician in the emergency department. A professional component for these services may not be billed separately by a physician in the emergency department, and no separate payment will be made to the physician in the emergency department for a professional component. The professional component will be reimbursed only to those providers who interpret a test and sign and issue the final report.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapter I of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these recipients only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the recipient.
- On written referral from the primary health care provider using the Practitioner Referral form (DMAS-70). This also applies to covering physicians.
- For other services covered by Medicaid which are excluded from the Client Medical Management Program requirements.

See "Exhibits" in Chapter I for details.

EMERGENCY ROOM SERVICES UNDER CLIENT MEDICAL MANAGEMENT

General Information

Reimbursement for emergency room services for Client Medical Management (CMM) recipients will be automatically paid if the Admitting (presenting signs/symptoms) diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD-9-CM CM Code (see "exhibits" at the end of this chapter for the list.)

CMM recipients must have a written primary care provider (PCP) referral in order for non-emergency services provided in the emergency room to be reimbursed at the all-inclusive rate of $30. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the recipient is responsible for the full cost of the emergency room visit. When billing for emergency room services, the attending physician bills evaluation and management codes with CPT codes 99281-99285 and enters "1" in Block 24I. When the PCP has referred the recipient to the emergency room, place the PCP's identification number in Block 17A on the HCFA-1500 (12-90) and attach the Practitioner Referral Form, DMAS-70. Write "attachment" in Block 10D. **PCP referral IS required for reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting.**

Outpatient Laboratory Procedures

Payment for laboratory services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The hospital laboratory may bill for the handling or conveyance of specimens sent to another laboratory by using Current Procedural Terminology (CPT) Code 99001. Only one specimen handling fee is allowed per outpatient visit. Laboratory procedures performed by outside sources at no charge to the practitioner or laboratory are not to be billed to Medicaid.

Whenever laboratory tests are performed that are generally a part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing:

- The CPT/HCPCS delineates 22 tests that are frequently done as part of a chemistry profile. When **two** or more of these lab tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. CPT/HCPCS Codes 80002-80019 (use Codes 80049-80092 for services delivered on or after January 1, 1998) are to be used, and the code used must correlate with the number of tests performed. Only one panel code is to be used per specimen. If only one procedure is performed, use the appropriate CPT/HCPCS procedure code which describes the individual test.

- Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code is to be used (85021-85031). CPT/HCPCS Codes 85021-85027 are to be used when specimens are tested using automated equipment, and CPT/HCPCS Code 85031 is to be used when specimens are tested manually.

If fewer than four components of a hemogram are performed, they are to be billed using the appropriate individual CPT/HCPCS codes.

The following laboratory services are specifically **excluded** from coverage and payment:

- Tests performed on a routine basis but not medically indicated by the patient's symptoms.

- Laboratory test professional component (Modifier A) for procedures performed in the physician's office, outpatient hospital, or in the independent laboratory. Payment for **supervision** and **interpretation** is included in the full procedure payment.

- Sensitivity studies when a culture shows no growth. Payment will be made only for the culture.

Results must be recorded in the patient's chart for all tests billed to Medicaid. Qualitative test results must be recorded as positive or negative.

Payment for the following tests will be made only to a pathologist, a hospital laboratory, or a participating laboratory. Specimens for the tests listed below may also be sent to the State Laboratory:

86171	Complement fixation tests, each
87116	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
87117	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); concentration plus isolation
87118	Culture, mycobacteria, definitive identification of each organism.
87190	Sensitivity studies, antibiotic, tubercle bacillus (TB, AFB), each drug
87250	Virus, identification; inoculation of embryonated eggs, or small animal, includes observation and dissection

ClaimCheck

Beginning with claims received on or after July 1, 2001, Claim Check will be implemented by DMAS. ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS will utilize ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS will make the necessary voids or adjustment of the claim(s) as a result of ClaimCheck.

Outpatient Rehabilitation Services

Rehabilitation services rendered to outpatients are covered if they meet the conditions specific in the policy statement on Criteria for Coverage of Rehabilitation Services. Refer to the *Rehabilitation Manu*al issued by DMAS for criteria on covered services.

DMAS categorizes general physical outpatient rehabilitation into two subgroups: acute conditions and long-term, non-acute conditions (effective July 1, 1995). Acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration of less than 12 months and in which progress toward established goals is likely to occur frequently. Long-term, non-acute conditions are defined as those conditions which are expected to require rehabilitative services for a duration greater than 12 months and in which progress toward established goals is likely to occur slowly.

Covered outpatient rehabilitative services for acute conditions and long-term, non-acute conditions include physical and occupational therapy and speech/language pathology

services. Any of these services shall not be contingent upon the provision of another service.

A physician recertification is required at least every 60 days for acute rehabilitative services and at least annually for long-term, non-acute rehabilitative services. The physician review and recertification of the plan of treatment must be completed at least every 62 days for all patients, according to federal requirements. The physician certification (plan of care) prior to the start of services and the required periodic recertification (plan of care renewal) must be signed and dated by the physician prior to the initiation or the continuation of service. The physician who reviews the plan of care and certifies or recertifies the need for service must sign the document.

Defining a condition as acute or as long-term, non-acute is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care remains unchanged. Plans of care must still include measurable long-term goals with anticipated dates of achievement. Plans of care must be renewed by the physician at any time long-term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual patient.

BENEFICIARY COPAYMENTS

The Virginia Medical Assistance Program requires copayment for certain services. This policy statement describes the application of copayment requirements to inpatient and outpatient hospital patients.

General

Recipients are required to share the cost of inpatient and outpatient hospital care. These copayments are:

$100 per hospital admission

$ 3 per non-emergency outpatient hospital visit

Copayment does not apply to an emergency or life-threatening condition. If an emergency or life-threatening condition exists, enter the appropriate code in Locator 19 of the UB-92 HCFA-1450 to ensure that the copayment will not be deducted from the calculated payment.

Copayments for Children under Age 21

The Virginia Medical Assistance Program prohibits imposition of copayment requirements for any services rendered to children under age 21.

Other Copayment Exclusions

No copayment is to be collected for any service which is pregnancy-related (services delivered to pregnant women if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy (e.g., prenatal, delivery, postpartum care).

No copayment is to be collected for family planning services.

There are no copayments for services rendered to individuals who are residents of hospices, intermediate care facilities for the mentally retarded, nursing homes, tuberculosis, or mental hospitals.

Services to a recipient cannot be denied solely because of his or her inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

Inpatient Services for Medicare-Eligible Patients

A $100 copayment must be collected by the hospital for recipients who receive non-emergency inpatient hospital services, including those who have Medicare Part A coverage.

A $100 Medicaid hospital deductible will automatically be subtracted from the Medicare Part A deductible charge submitted on the Medicaid Title XVIII Deductible and Coinsurance Invoice (DMAS-30) and Adjustment (DMAS 31).

No Medicaid hospital deductible will be collected for admissions which are deemed by the attending medical staff to constitute an emergency. If the Medicare Part A deductible charge submitted on the DMAS-30 or the DMAS 31 includes charges for emergency services, the notation "Emergency/Accident Treatment" must be written in the "Remarks" section of the invoice. In addition, indicate the line item to which it applies. In the absence of a medical emergency condition notation on the DMAS-30 or DMAS 31, the $100 Medicaid deductible will automatically be subtracted from the Medicaid payment and will appear in the copay column of the Hospital Title XVIII Remittance Voucher.

Bill Medicaid for the total hospitalization for Medicaid dually eligible recipients who exhausted their Medicare coverage while hospitalized. Any payments made by Medicare or Medicaid must be placed on the UB-92 HCFA-1500. Refer to the Billing Instructions, Chapter V, for additional information.

Outpatient Services for Medicare-Eligible Patients

A $3 copayment must be collected from Medicaid recipients for non-emergency hospital services billed under Medicare Part B, unless they are subject to the exemptions outlined below.

Medicare Part B hospital charges must be separated from Medicare Part A charges on the Medicaid Title XVIII Invoice (DMAS-30) or Adjustment (DMAS 31). It is necessary to complete another line item on the invoice to accomplish this. This means the provider cannot check both the A and B indicators in Block 8 on the same line item.

A $3 copay will be subtracted automatically for medically needy recipients from the Part B charges on the Medicaid XVIII Invoice and will appear in the copay column of the Hospital Title XVIII Remittance Voucher. If the Part B charges include charges for emergency services, the notation "Emergency/Accident Treatment" must be placed in the "Remarks" section of the invoice to avoid having the copay subtracted automatically. In addition, indicate the line item on the invoice to which the emergency notation applies.

INPATIENT DENTAL SERVICES

If a patient is hospitalized solely for covered dental treatment, the professional services of the dentist and the inpatient hospital services are covered if the appropriate authorizations have been obtained and approval given by WVMI. The only exception to this policy is a covered service resulting from an accidental injury. In this instance, the dentist and the hospital may obtain retro-authorization.

When a patient is hospitalized for dental treatment, but hospitalization is required to ensure proper medical management, control, or treatment of a non-dental impairment, the inpatient hospital services must be authorized by WVMI for all inpatient admissions. An example is a patient with a history of repeated heart attacks who must have all of his or her teeth extracted. The physician responsible for the treatment or management of the non-dental impairment must certify to the necessity for the patient's hospitalization. The certification must be completed at the time of admission and according to the guidelines for admission certification for acute care as specified in Chapter VI of this manual.

MANDATORY OUTPATIENT SURGICAL AND DIAGNOSTIC PROCEDURES PROGRAM

Program Requirements

Certain selected surgical and diagnostic procedures may be effectively performed on an outpatient basis. Therefore, the Commonwealth of Virginia mandated the implementation of a Mandatory Outpatient Surgical and Diagnostic Procedures Program. For all practitioner billings [HCFA-1500 (12-90)] and inpatient hospital billings (UB-92 HCFA-1450) prior to the implementation of hospital prior authorization, Virginia Medicaid will not reimburse the hospital or practitioner for the selected outpatient surgical or diagnostic procedures listed in Mandatory Outpatient Surgical Procedures when performed on an inpatient basis unless it meets one of the exceptions to this policy. (See “Exhibits” at the end of this chapter for the list.) This policy applies to all Medicaid-eligible patients regardless of any other medical coverage. However, for any inpatient claim denied, the hospital may submit ancillary services performed for the inpatient denial within the first three days of hospitalization on an outpatient invoice.

For inpatient hospital billings after the implementation of hospital prior authorization, DMAS will reimburse the hospital for these procedures if prior authorized. Practitioners must still attach documentation of medical necessity to the HCFA-1500 when billing for these services.

Exceptions

Exceptions as defined below must be well documented and support the medical necessity for these procedures when performed on an inpatient basis.

- An existing medical condition requires prolonged post-operative observation by skilled medical personnel (e.g., heart disease or severe diabetes).
- The recipient had been admitted to a hospital for another procedure or condition, and the surgeon decides that one of the listed procedures is also necessary or is done in conjunction with the procedure requiring hospitalization.
- Another procedure that requires the inpatient setting may follow the initial procedure (e.g., gynecological laparoscopy followed by oophorectomy).

- Adequate outpatient facilities are not available within a reasonable distance (i.e., 50 miles) requiring the procedure to be rendered on an inpatient basis; in this case, a one-day inpatient hospital stay would be allowed unless a longer stay is medically necessary.

All physician invoices will pend for review when the site of the service is inpatient and a listed outpatient surgical or diagnostic procedure code is used. All inpatient hospital invoices for one of the listed outpatient surgical or diagnostic procedure codes also will be reviewed for the necessity of the inpatient setting if the claim is for a period prior to the implementation of hospital prior authorization. Complete case documentation must support the medical necessity for these procedures when performed on an inpatient basis. Payment will be approved only when appropriate justification for inpatient necessity is provided on or accompanies both invoices.

Note: **Physicians** billing on the HCFA-1500 (12-90) billing form must continue to use the **CPT/HCPCS** list of codes.

Hospitals billing on the Inpatient Hospital Invoice (UB-92 HCFA-1450) must use the **ICD-9-CM** list of codes.

For dates of service after the implementation of the hospital's prior authorization for inpatient services, claims for these services will be paid only if the inpatient admission is authorized by WVMI.

SUBMISSION OF CLAIMS FOR NONRESIDENT ALIENS

Medical Coverage for Nonresident Aliens

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended, requires Medicaid to cover emergency services for nonresident aliens when these services are provided in a hospital emergency room, inpatient hospital setting, or dialysis center.

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks;
- Traumatic injuries;
- Deliveries;
- Acute coronary difficulties;
- Emergency surgeries (e.g., appendectomies);
- Episodes of acute pain (etiology unknown);
- Acute infectious processes requiring intravenous antibiotics;
- Fractures; and
- End-stage renal disease.

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care;
- Physician services provided in a covered location;
- Inpatient hospitalization not to exceed limits established for other Medicaid recipients;
- Services provided at a dialysis center for renal dialysis;
- Ambulance service to the emergency room or hospital; and
- Inpatient and outpatient pharmacy services related to the emergency treatment.

Hospital outpatient planned procedures or follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Local departments of social services determine the eligibility of the nonresident alien to receive emergency Medicaid coverage based on normal eligibility criteria and the documentation from the provider of services that the emergency services have been provided. Referrals to the local social services agency may come from the provider or from the nonresident alien.

The documentation of the emergency treatment will be verified by the local social services agency through the patient's medical record obtained from the provider. This documentation must include all required Medicaid forms and a copy of the recipient's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20 for admissions on or before December 31, 1999. For admissions on or after January 1, 2000, and the reimbursement under DRG payment methodology, this 21-day limit has been removed for all inpatient services except psychiatric services. The local social services agency will submit this documentation to Medicaid for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the recipient is found eligible and the emergency room coverage is approved by Medicaid, each provider rendering the emergency care will be notified via the Emergency Medical Certification Form of the recipient's temporary eligibility number, the conditions for which treatment or services will be covered, and the dates for which the eligibility number is valid. Coverage for nonresident aliens is valid only for the conditions and time stated on this form. This form will also be used to notify providers that a nonresident alien is not eligible for emergency care. Eligibility for non-resident alien clients receiving dialysis is limited to routine dialysis services. Clients who have additional services that are not directly related to dialysis services (emergency room visits, planned outpatient hospital service, inpatient admission) must have these services authorized by DMAS in order to be reimbursed by DMAS.

To submit a claim for these emergency services for a nonresident alien:

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.

- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been

submitted and reviewed and therefore, does not need to be duplicated with this claim.

- Submit the claim using the preprinted envelopes supplied by Medicaid or by mailing the claim directly to the appropriate post office box.

  NOTE: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.

EXHIBITS

TABLE OF CONTENTS

MEDICAID INPATIENT PSYCHIATRIC SERVICES CRITERIA

These criteria will be utilized to determine the medical necessity for psychiatric inpatient admissions and lengths of stay.

A. Definitions:

"**Acute**" means within 24 hours.

"**Active Treatment**" means implementation of a professionally developed and supervised individual plan of care.

"**Ambulatory Care**" means services provided in the recipient's home community which may include outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.

"**On Admission**" means within four hours.

"**Recent Onset**" means within one week.

"**Severe Psychiatric Disorder**" means clinical manifestation, symptoms, or complications which are so severe as to preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and which require 24-hour nursing/medical assessment, intervention, or monitoring.

B. Severity of Illness

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by DMAS to determine whether or not a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the recipient.

    a. The recipient is currently receiving ambulatory care and not responding to treatment; **or,**

    b. The recipient's identified condition is escalating; **or**,

    c. The recipient's condition is of an emergency nature, with recent onset or is a reoccurrence of a previous acute psychotic condition; **or**,

    d. The recipient's condition requires monitoring of newly prescribed drugs with high rate of complication/adverse reactions; **or**,

    e. The recipient's condition requires monitoring for toxic effects from therapeutic psychotropic drugs.

2. Individuals admitted for inpatient hospital level of care must have been diagnosed with a severe psychiatric disorder. There must be documented evidence of recent onset of one of the following conditions:

a. Current suicide attempt or ideation. Behavior reflecting a suicide attempt or suicidal intent with a plan. Degree of intent, availability of method, and immediacy of plan should support the decision to admit; **or**,

b. Current assaultive, self-mutilative, or destructive behavior. Immediate danger to self or others, both, is apparent. This behavior must require intensive psychiatric medical management and nursing interventions on a 24-hour basis; **or,**

c. Current hallucinations (visual or auditory), bizarre, or delusional behavior. Patient exhibits reality testing deficits or hypomanic behavior severe enough to present danger to self and others; **or**,

d. Inability to perform activities of daily living because of severe psychiatric symptoms. This may include, psychomotor retardation, severe depression, social withdrawal, agitation, autistic, or catatonic behavior; **or**,

e. Disorientation or memory impairment to the degree of endangering welfare; **or,**

f. Loss of body control, total body rigidity, immobility, seizures (withdrawal or toxic) or obsessive compulsive behavior which cannot be controlled.

3. The following disorders do not justify inpatient hospital admission unless the other severity of illness criteria in B (1 and 2) above or medical criteria are also met.

a. Organic Brain Syndrome

b. Hyperactivity

c. Attention Deficit Disorders

d. Dyslexia

e. Behavior or Personality Disorders

f. Eating Disorders

g. Alcohol and or Drug Abuse

h. Mental Retardation

i. Alzheimer's Disease

4. DMAS will not reimburse for any services that do not meet the severity of illness criteria as listed in B (1 and 2) above. Some examples of non-reimbursable services include:

a. Remedial education;

b. Evaluation for educational placement or long-term placement;

c. Day care;

d. Behavioral modification;

e. Psychological testing for educational diagnosis, school or institutional admission or placement, or as a result of a court order;

f. Alcohol or drug abuse therapy;

g. Residential treatment;

h. Partial hospitalization programs; and

i. In lieu of incarceration for legal offenses.

C. Intensity of treatment required - To meet criteria for continued stay, the intensity of treatment must relate to the severity of illness with the goal of improving or preventing regression of the recipient's condition so services will no longer be needed.

1. The active treatment plan must relate to the admission diagnosis and reflect:

a. At least one of the following:

(1) Physical restraint/seclusion/isolation; **or,**

(2) Suicidal/homicidal precautions; **or**,

(3) Escape precautions; **or,**

(4) Drug therapy (any route) requiring specific close medical supervision; **and,**

b. All of the following:

(1) A licensed professional (psychiatrist, clinical psychologist, psychiatric clinical nurse specialist, licensed clinical social worker, licensed professional counselor) provides individual therapy five out of seven days; **and**,

(2) A minimum of 21 hours, excluding individual treatment, school attendance, and family therapy, of appropriate treatment interventions are provided each week (i.e., group, with specific topics focused to the patient's needs; socialization, educational, behavioral intervention; play/art/music therapy; occupational therapy; and physical therapy). These modalities of treatment may be a part of the total treatment plan, but must not be the major treatment modality; **and**,

(3) The family, caretaker, or case manager is involved on an ongoing basis with treatment planning and participates in

family therapy at a minimum of once per week unless documentation demonstrates, based on the treatment plan, why it is not feasible and addresses alternative involvement in therapy; **and,**

(4) Active treatment and discharge planning begin at admission.

2. Medical record documentation must include:

a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; **and,**

b. Continued necessity for skilled observation, structured intervention, and support that can only be provided at the hospital level of care; **and**,

c. Concurrent documentation of therapies as provided, including individual treatment, according to the treatment plan, specific to hours and number of days provided, topics covered and response to the therapy; **and,**

d. If the minimum treatment outlined in C.1.b. (2) above is not provided, documentation of why the individual was unable to participate.

3. Therapeutic passes:

a. One therapeutic day pass is allowed, if the goals of the day pass are documented prior to the day pass and, if on return, the effect of the day pass is documented. If the first pass is determined not to have reached the goals, and indications exist, a second day pass may be permitted. Day passes which are not a part of the written plan of treatment or documented as to expected and experienced therapeutic effect, are not permitted.

b. Overnight passes are not permitted.

D. Expected outcome/discharge screen. Continued hospital level of care is not appropriate and will not be covered when one or more of the following exist:

1. The stabilization of presenting symptoms with demonstrated ability to perform activities of daily living appropriate for age and to function appropriately within hospital milieu environment; **or,**

2. The treatment required can be provided in a less restrictive environment; **or,**

3. The type/dosage of major psychotropic medication has been unchanged for the last five days or there is medical documentation to support no variation in drug therapy; **or,**

4. There has been no documented evidence of a change in treatment plan when the recipient has not responded in a seven-day period; **or,**

5. The recipient refuses to cooperate with the treatment plan.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

EMERGENCY MEDICAL CERTIFICATION

APPLICANT'S NAME

CASE NUMBER

TO: DIVISION OF PROGRAM OPERATIONS
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

I. REFERRAL SECTION

THE ABOVE-NAMED INDIVIDUAL HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____ (DATE) .

INDIVIDUAL'S STATUS ☐ A ☐ B ☐ C

ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____ WORKER#: _____ DATE: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINED THAT THE MEDICAL CONDITION

☐ IS AN EMERGENCY ☐ IS NOT AN EMERGENCY

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED: _____ TITLE: _____ DATE: _____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS.

REASON FOR DENIAL: _____

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____ TITLE: _____ DATE: _____

LOCAL AGENCY

CONFIDENTIAL

VA MEDICAID UTILIZATION MANAGEMENT

WVMI Use

WVMI Authorization _____

L.O.S. _____

☐ Initial Review ☐ Concurrent Review

A. Patient Medicaid ID: _____

B. Hospital Name: _____ Provider #: _____

Hospital Phone: _____ Extension: _____

Hospital Fax: _____ Contact Name: _____

C. Admitting Physician: _____ Phone: _____

D. Patient Name: _____

Last First MI

Date of Birth: _____ Sex: ☐ M ☐ F

E. Admission Type: ☐ Elective ☐ Urgent ☐ Emergency
Still a Patient? ☐ Yes ☐ No

F. Admission Date: _____ /Discharge Date: _____

G. Setting: ☐ Inpatient ☐ Inpatient Psych

H. ICD-9 Code(s): _____

Description: _____

I. Severity of Illness (Initial Only): _____

_____

J. Abnormal Lab/ Imaging Findings: _____

_____

K. Intensity of Service/ Treatment Plan: _____

_____

_____

Authorization does not guarantee reimbursement.

Voice			Fax	
800-299-9864 Toll-Free	•Continued stay for hospital inpatient, **press 1** •Continued stay for psychiatric inpatient, **press 2**	**804-648-3159** Richmond Area	888-243-2770 Toll-Free	804-648-6880 Richmond Area

WVMI
Psychiatric Facsimile Form

Confidential

Telephone Toll Free #: 800-299-9864
Telephone Local #: 648-3159

Facisimile Toll Free #: 888-234-2770
Facsimile Local #: 648-6880

Patient Name _____ D.O.B. _____

Patient Address _____ Sex M ____ F ____

_____ Medicaid Number _____

_____

Practitioner's Name _____ Practitioner's Phone _____

Provider Name _____ Provider Number _____

Provider Phone _____ Provider Fax _____

Initial Admission Date _____

FOR WVMI USE ONLY
Certification Number _____
Approved Dates _____

CSB Screening:

Screener _____ Date _____

Locality _____ Recommendation _____

TDO: Yes _____ No _____ Date _____

NOTE: Concisely address each area below.

1. Diagnoses (DSM IV - Axis 1-5)

AXIS I. _____

_____

_____

AXIS II. _____

AXIS III. _____

AXIS IV. _____

AXIS V. _____

2. Please include information regarding severity of problems and symptoms, level of distress, and impairment in functioning patient is exhibiting at this time.

_____

_____

_____

_____

_____

_____

_____

_____

WVMI
Psychiatric Facsimile Form

Confidential

3. Homicidal/ Suicidal Ideation: Yes _____ No _____ Plan: Yes _____ No _____
Describe thoughts, gestures, or attempts with dates of occurrences: _____

4. Physical Violence risk (if applicable): Low ____ Moderate ____ High ____
Describe any aggressive or violent acts with dates of occurrences: _____

5. Check any of the following special precautions currently in place or recently implemented. If discontinued, please note the date:

a. Suicide precautions	Date: _____	b. Elopement	Date: _____
c. Quiet Room	Date: _____	d. Seclusion	Date: _____
e. Intermittent restraint to prevent harm to self or others	Date: _____	f. Assault precautions	Date: _____

6. List current medications and dosages: _____

Response to medication regime: _____

Side effects: _____

Last blood level, if pertinent: _____

Explain need for further monitoring and adjustment: _____

Frequency of maintenance med checks: _____

WVMI Psychiatric Facsimile Form	Confidential

Address each area below for subsequent reviews. A treatment plan and current status with measurable objectives may be attached.

Date of last treatment plan review: _____

7. **Treatment Goals** (should be measurable outcomes in terms of specific behaviors being targeted for treatment or clinical descriptive interventions addressing changes or resolution of problems):

_____
_____
_____
_____

8. **Progress Toward Treatment Goals** (refer to previous goals and cite specific changes/obstacles to change):

_____
_____
_____
_____

9. **Patient Progress:** Since the last review, the patient's functioning has:

Significantly Improved: ___ Somewhat Improved: ___ Remained Unchanged: ___ Regressed:___

Please describe specific changes in the patient's behavior, mood, etc. What *measurable* changes do you expect before treatment ends?

_____
_____
_____
_____

10. Has family/significant other been notified? ___ Yes ___ No

If no, give explanation:

_____
_____

11. Have there been attempts at therapeutic re-entry into the community and/or home setting?

___ Yes ___ No

Comments: _____
_____
_____

WVMI
Psychiatric Facsimile Form

Confidential

12. Discharge/Disposition Plan: ___ Yes ___ No

Explain:

_____

_____

_____

Signature: _____ Phone Name: _____

Print Name: _____ Date: _____

00100-00190	Cholera
00200-00290	Typhoid, Paratyphoid Fever
00300-00390	Salmonella Infections
00400-00490	Shigellosis
00500-00590	Other Food Poisoning (bacterial)
00600-00690	Amebiasis
00700-00790	Other Protozoal Diseases
00800-00809	Intestinal Infection due to Other Organisms
0081	Arizon Group of Paracolon Bacilli
0082	Aerobacter Aerogenes
0083	Proteus (mirabilis) (morganii)
00840-00850	Other Specified Bacteria
00860-00869	Enteritis due to Specified Virus
0088	Other Organism, not elsewhere classified
00900-00930	Ill Defined Intestinal Infections
01000-01896	Tuberculosis
02000-02090	Plague
02100-02190	Tularemia
02200-02290	Anthrax
02300-02390	Brucellosis
02400-02500	Glanders, Melioidosis
02600-02690	Rat Bite Fever
02700-02790	Other Zoonotic Bacterial Diseases
03000-03090	Leprosy
03100-03190	Diseases due to Other Mycrobacteria
03200-03290	Diphtheria
03300-03390	Whooping Cough
03440-03410	Streptococcal Sore Throat and Scarlett Fever
035	Erysipelas
03600-03690	Meningococcal Meningitis, Encephalitis, Carditis
037	Tetanus
038	Septicemia
03900-03990	Actinomycotic Infections
04000-04030	Other Bacterial Diseases
04081-04089	Tropical Pyomyosistis; Other Bacterial disease-toxic shock syndrome
04500-04593	Acute Poliomyelitis
04700-04790	Meningitis due to Enterovirus
048	Other Enterovirus of CNS
04900-04990	Non-Arthropod Virus of CNS, Encephalitis, Meningitis
05000-05090	Smallpox
05200-05290	Chickenpox
05300-05390	Herpes Zoster
05410-05490	Herpes Simplex
05500-05510	Post Measles Encephalitis or Pneumonia
05571	Measles Keratoconjunctivitis
05600-05690	Rubella with Neurological and Other Specified Complications
06000-06090	Yellow Fever
061	Dengue
06200-06290	Mosquito-Borne Viral Encephalitis
06300-06390	Tick-Borne Encephalitis
064	Viral Encephalitis by Arthropod
06500-06590	Arthropod-Borne Hemorrhagic Fever

06600-06680	Other Arthropod-Borne Viral Diseases
07000-07060	Viral Hepatits
07100-07101	Rabies
07200-07290	Mumps
07300-07390	Ornithosis
07400-07423	Coxsackie
0774	Epidemic Hemorrhagic Conjunctivitis
07860-07861	Hemorrhagic Nephrosonephritis
07870-07871	Arenaviral Hemorrhagic Fever
0796	Respiratory Syncytial Virus (RSV)
08000-08190	Typhus Fever
08200-08290	Tick-Borne Rickettsioses
08300-08390	Other Rickettsioses
08400-08490	Malaria
08500-08590	Leishmaniasis
08600-08690	Trypanosomiasis
08700-08790	Relapsing Fever
08800-08890	Other Arthropod-Borne Diseases
09000-09790	Syphillis
0980	Gonococcal Infections
09810-09819	Acute, of Upper Genitourinary Tract
09840-09889	Gonococcal Infections of Eye, Joint, or Other Specified Sites
09900-09930	Other Venereal Diseases
09940-09949	Other Nongonococcal Uretritis
09950-09990	Other Veneral Disease related to Chlamydia Trachomatis
1000-10081	Leptospirosis
1124	Candidal Pneumonia
11281-11285	Candidal Endocarditis
1142	Coccidioidal Meningitis
11501-11505	Histoplasmosis with Meningitis, Retinitis, Pericarditis, Pneumonia
11511-11515	Infection by Histoplasma Duboisii
11591-11595	Histoplasmosis, unspecified
13000-13090	Toxoplasmosis
13630-13630	Pneumocystosis
24200-24291	Thyrotoxicosis
2450	Acute Thyroiditis
2463	Hemorrhage, Infarct of Thyroid
25002	Diabetes Mellitus without mention of complication, Type I, uncontrolled
25003	Diabetes Mellitus without mention of complication, Type II, uncontrolled
25010-25033	Diabetes with Ketoacidosis; Hyperosmolality; or Coma
25042-25043	Diabetes with Renal Manifestations; Type I or II; uncontrolled
25052-25053	Diabetes with Ophthalmic Manifestations; Type I or II; uncontrolled
25062-25063	Diabetes with Neurological Manifestations; Type I or II; uncontrolled
25072-25073	Diabetes with Peripheral Circulatory Disturbances; Type I or II; uncontrolled
25082-25083	Diabetes with Other Specified Manifestations; Type I or II; uncontrolled
25092-25093	Diabetes with Unspecified Complications; Type I or II; uncontrolled

25100-25120	Hypoglycemia
2521	Hypoparathyroidism (parathyroiditis, tetany)
2535	Diabetes Insipidus
2554	Corticoadrenal Insufficient; Addisonian Crisis
262	Other Severe, Protein-Calorie Malnutrition
2740	Gouty Arthropathy
27541	Hypocalcemia
27542	Hypercalcemia
27600-27680	Disorders of Fluid, Electrolyte, and Acid-base Balance
28262	Sickle Cell Crisis
28311	Hemolytic-uremic Syndrome
2851	Acute Post Hemorrhagic Anemia
28600-28790	Coagulation Defects; Other Hemorrhagic Conditions
29011	Presenile Dementia with Delirium
2903	Senile Dementia with Delirium
29041	Arteriosclerotic Dementia with Delirium
2910	Alcohol Withdrawal Delirium
2913	Alcohol Withdrawal Hallucinosis
29181	Alcohol Withdrawal
29212	Drug Induced Hallucinosis
29281	Drug Induced Delirium
2930	Transient Organic Psychotic Condition- acute delirium
29503-29504	Schizophrenic Disorder, Simple Type, with Acute Exacerbation
29513-29514	Schizophrenic Disorder, Disorganized Type, with Acute Exacerbation
29523-29524	Schizophrenic Disorder, Catatonic Type, with Acute Exacerbation
29533-29534	Schizophrenic Disorder, Paranoid Type, with Acute Exacerbation
29543-29544	Acute Schizophrenic Episode
29553-29554	Latent Schizophrenia, with Acute Exacerbation
29563-29564	Residual Schizophrenia, with Acute Exaceration
29573-29574	Schizophrenic Disorder, Schizo-Affective Type, with Acute Exacerbation
29583-29584	Other Specified Types of Schizophrenia, with Acute Exacerbation
29593-29594	Unspecified Schizophrenic, with Acute Exacerbation
29603-29604	Affective Psychoses, Manic Disorder, single episode
29613-29614	Affective Psychoses, Manic Disorder, recurrent episode
29623-29624	Affective Psychoses, Major Depression, single episode
29633-29634	Affective Psychoses, Major Depression, recurrent episode
29643-29644	Affective Psychoses, Bipolar Affective Disorder, Manic
29653-29654	Affective Psychoses, Bipolar Affective Disorder, Depressed
29663-29664	Affective Psychoses, Bipolar Affective Disorder, Mixed
32000-32299	Meningitis
32300-32390	Encephalitis, Myelitis, and Encephalomyelitis
32400-32490	Intracranial and Intraspinal Abscess
325	Phlebitis and Thrombophlebitis of Intracranial Venous Sinuses
32600-32690	Late Effects of Intracranial Abscess or Pyrogenic Infection
33383	Spasmodic Torticollis
33392	Neuroleptic Malignant Syndrome
3343	Other Cerebellar Ataxia
3361	Vascular Myelopathies; Acute Infarct of Spinal Cord
34511	Convulsive Epilepsy, Intractable
34520-34530	Petit Mal and Grand Mal Status

34540-34541	Partial Epilepsy, with Impairment of Consciousness
34561	Infantile Spasms, with Intractable Epilepsy
34571	Epilepsia Partilis Continuous with Intractable Epilepsy
34581	Other Forms of Epilepsy with Intractable Epilepsy
34591	Epilepsy, Unspecified, with Intractable Epilepsy
34601	Classical Migraine, with Intractable Migraine, so stated
34611	Common Migraine, with Intractable Migraine, so stated
34621	Variants of Migraine, with Intractable Migraine, so stated
34681	Other Forms of Migraine, with Intractable Migraine, so stated
34691	Migraine, Unspecified with Intractable Migraine
3481	Anoxic Brain Damage
34830-34840	Encephalopathy; Compression of Brain
3485	Cerebral Edema
3490	Reaction to Spinal or Lumbar Puncture
3491	Nervous System Reaction from Surgically Implanted Device
34981	Cerebrospinal Fluid Rhinorrhea
34982	Toxic Encephalopathy
3501	Trigeminal Neuralgia
3510	Bell's Palsy
3570	Acute Infective Polyneuritis
3580	Myasthenia Gravis
36000-36019	Purulent and Other Endophthalmitis
36100-36105	Retinal Detachment with Retinal Defect
3612	Serous Retinal Detachment
36181-36190	Other Forms of Retinal Detachment
36230-36243	Retinal Vasular Occlusion or Separation Retinal Layers
36281	Retinal Hemorrhage
36361-36363	Choroidal Hemorrhage or Rupture
36370-36372	Choroidal Detachment or Hemorrhage
36400-36405	Acute and Subacute Iridocyclitis
36421-36441	Certain Types of Iridocyclitis
36504	Ocular Hypertension
36522	Acute Angle-Closure Glaucoma
36565	Glaumoma Associated with Ocular Trauma
36811-36812	Sudden or Transient Vision Loss
37000	Corneal Ulcer, unspecified
37003	Central Corneal Ulcer
37006	Perforated Corneal Ulcer
37020-37024	Superficial Keratitis without Conjunctivitis
37040	Keratoconjunctivitis, unspecified
37044	Keratitis or Keratoconjunctivitis in Exanthema
37050-37059	Interstitial and Deep Keratitis, including Corneal Abscess
37120-37124	Corneal Edema
37200-37202	Acute Conjunctivitis
37205	Acute Atopic Conjunctivitis
37220-37222	Blepharoconjunctivitis
37233	Conjunctivitis in Mucocutaneous Disease
37271-37273	Hyperemia of Conjunctiva, Conjunctival Hemorrhage or Edema
37301-37302	Blepharitis, Unspecified, Ulcerative or Squamous
37311-37312	Hordeolum Externum or Internum
37313	Abscess of Eyelid
37481	Hemorrhage of Eyelid
37486	Retained Foreign Body of Eyelid

37500-37501	Dacryadenitis, acute or unspecified
37530-37533	Acute and Unspecified Inflammation of Lacrimal System
37600-37604	Acute Inflammation of Orbit
37632-37636	Orbital Hemorrhage, Edema, Congestion or Intermittent, Pulsating Exophthalmos
37701	Papilledema, Unspecified or Associated with Intracranial Pressure
37732	Retrobulbar Neuritis (acute)
37741-37749	Other Disorders of Optic Nerve
37851-37854	Paralytic Strabismus
37923	Vitreous Hemorrhage
37926	Vitreous Prolapse
37932-37934	Subluxation; Anterior or Posterior Dislocation of Lens
38001	Acute Perichondritis of Pinna
38010-38014	Infective Otitis Externa
38022	Other Acute Otitis Externa
38031	Hematoma of Auricle or Pinna
38200-38202	Acute Suppurative Otitis Media, with or without Spontaneous Rupture of Ear Drum, or with Diseases classified elsewhere
38300-38302	Acute Mastoiditis; Subperiosteal Abscess of Mastoid; Acute Mastoiditis with other complications
38400-38401	Acute Myringitis, Bullous or unspecified
38420-38425	Perforation of Tympanic Membrane
38583	Retained Foreign Body of Middle Ear
38600-38603	Active Meniere's Disease
38610-38620	Other and Unspecified Peripheral Vertigo
38630-38635	Labrinthitis
38811	Acoustic Trauma (explosive) to Ear
38812	Noise Induced Hearing Loss
3882	Sudden Hearing Loss, Unspecified
38861	Spinal Fluid Otorrhea
38870-38871	Otalgia, Unspecified or Otogenic Pain
39100-39190	Rheumatic Fever with Heart Complications
39891	Rheumatic Heart Failure (congestive)
4010	Malignant Hypertension
40200-40201	Hypertensive Heart Disease; Malignant, with or without Congestive Heart Failure
40211	Hypertensive Heart Disease; Benign, with Congestive Heart Failure
40291	Hypertensive Heart Disease; Unspecified, with Congestive Heart Failure
40301	Malignant Hypertensive Renal Disease with Renal Failure
40311	Benign Hypertensive Renal Disease with Renal Failure
40391	Unspecified Hypertensive Renal Disease with Renal Failure
40400-40403	Malignant Hypertensive Heart Disease and Renal Failure with Renal Failure
40411-40413	Benign Hypertensive Heart and Renal Disease
40491-40493	Unspecified Hypertensive Heart and Renal Disease
40501	Malignant Secondary Hypertension, Renovascular
41000-41189	Myocardial Infarction
41300-41390	Angina Pectoris
41410-41411	Aneurysm of Heart
41412	**Aneurysm and Dissection of Heart, Dissection of Coronary**

Artery

41500-41519	Acute Cor Pulmonale; Pulmonary Embolism
42000-42099	Acute Pericarditis
42100-42190	Acute and Subacute Endocarditis
42200-42299	Acute Myocarditis
42300-42390	Other Diseases of the Pericardium
42490-42499	Endocarditis, Valve unspecified
42600-42790	Conduction Disorders
42800-**42810**	Heart Failure, specified
42821	**Systolic Heart Failure, Acute**
42823	**Systolic Heart Failure, Acute or Chronic**
42831	**Diastolic Heart Failure, Acute**
42833	**Diastolic Heart Failure, Acute or Chronic**
42841	**Combined Systolic and Diastolic Heart Failure, Acute**
42843	**Combined Systolic and Diastolic Heart Failure, Acute or Chronic**
42890	**Heart Failure, Unspecified**
4290	Myocarditis, unspecified
42940-42940	Functional Disturbances After Cardiac Surgery
42950-42960	Rupture of Chordae Tendineae or Papillary Muscle
42971-42979	Certain Sequelae of Myocardial Infarction, not elsewhere classified
430	Subarachnoid Hemorrhage
431	Intracerebral Hemorrhage; Other and Unspecified Intracranial Hemorrhage
4320	Nontraumatic Extradural Hemorrhage
4321	Subdural Hemorrhage
4329	Unspecified Intracranial Hemorrhage
43300-43491	Occlusion or Stenosis of Cerebral and Precerebral Arteries
43500-43590	Transient Cerebral Ischemia
436	Acute Ill-Defined Cerebrovascular Disease; Stroke
43720-43730	Hypertensive Encephalopathy; Cerebral Aneurysm
4376	Nonpyogenic Thrombosis of Venous Sinus
4377	Transient Global Amnesia
44021-44024	Atherosclerosis of the Extremities; with Claudication, Rest Pain, Ulceration, Gangrene
44100-44290	Aortic and Other Aneurysms
44321-44329	**Dissection of Artery**
44400-44490	Arterial Embolism and Thrombosis
44501-44502	**Anteroembolism**
44581-44589	**Chronic Venous Hypertension**
44600-44610	Polyartertis Nodosa and Allied Conditions
44620-44670	Hypersensitivity Angiitis
44700-44790	Other Disorders of Arteries and Arterioles
45100-45199	Phlebitis and Thrombophlebitis
45200-45201	Portal Vein Thrombosis
45300-45399	Other Venous Embolism and Thrombosis
4560	Esophageal Varices with Bleeding
45620	Esophageal Varices in Diseases classified elsewhere with Bleeding
45700-45720	Postmastectomy Lymphedema Syndrome; Other Lymphedema; Lymphangitis
4580	Orthostatic Hypotension

4582	Istrogenic Hypotension
4588	Other Specified Hypotension
4590	Hemorrhage, Unspecified
46401	Acute Laryngitis with Obstruction
46451	Supraglottis with Obstruction
46411	Acute Layngitis and Tracheitis with Obstruction
46421	Acute Laryngotracheitis with Obstruction
46430-46431	Acute Epiglottitis
4644	Croup
46611-46619	Acute Bronchiolitis
475	Peritonsillar Abscess
47821-47825	Cellulitis, Abscess or Edema of Pharynx; Para or Retropharynx
47830-47834	Paralysis of Vocal Cords or Larynx
4786	Edema of Larynx
47871-47875	Other Diseases of Larynx, not elsewhere classified
48000-48780	Viral, Bacterial, Staphylococcus or Other Pneumonia
49121	Obstructive Chronic Bronchitis with Acute Exacerbation
49301	Extrinsic Asthma with Status Asthmaticus
49302	Extrinsic Asthma with Status Asthmaticus with Acute Exacerbation
49311	Intrinsic Asthma with Status Asthmaticus
49312	Intrinsic Asthma with Status Asthmaticus with Acute Exacerbation
49321	Chronic Obstructive Asthma with Status Asthmaticus
49322	Chronic Obstructive Asthma with Acute Exacerbation
49391-49392	Asthma; Unspecified with Status Asthmaticus or with Acute Exacerbation
4941	Bronchiestasis with Acute Exacerbation
50600-50630	Acute Respiratory Conditions due to Chemical Fumes and Vapors
50700-50780	Pneumonitis due to Solids or Liquids
5080	Acute Pulmonary Manifestations due to Radiation
51000-51090	Empyema
51100-51190	Pleurisy
51200-51280	Pneumothorax
51300-51310	Abscess of Lung and Mediastinum
5180	Pulmonary Collapse
51840-51850	Acute Edema of Lung; Pulmonary Insufficiency Following Trauma or Surgery
51881-51882	Acute Respiratory Failure
51900-51909	Tracheostomy Infection and Complications
52511	Loss of Teeth Due to Accident, Extraction, or Local Peridontal Disease
5283	Celluitis and Abscess of Soft Tissues
5300	Achalasia and Cardiospasm
53020-53040	Ulcer, Stricture, Stenosis or Perforation
5307	Gastroesophageal Laceration-Hemorrhage Syndrome
53082	Esophageal Hemorrhage
53084	Tracheoesophagefistula
53100-53161	Gastric Ulcer; with Hemorrhage, Perforation or Obstruction; acute or chronic
53171	Gastric Ulcer; Chronic with Obstruction
53191	Gastric Ulcer; Unspecifieas acute or chronic, with obstruction

53200-53261	Duodenal Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53271	Duodental Ulcer; Chronic with Obstruction
53291	Duodental Ulcer; Unspecified with Obstruction
53300-53361	Peptic Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53371	Peptic Ulcer; Chronic with Obstruction
53391	Peptic Ulcer; Unspecified with Obstruction
53400-53461	Gastrojejunal Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53471	Gastrojejunal Ulcer; Chronic with Obstruction
53491	Gastrojejunal Ulcer; Unspecified with Obstruction
53501	Acute Gastritis with Hemorrhage
53511	Atrophic Gastritis with Hemorrhage
53521	Gastric Mucosal Hypertropy with Hemorrhage
53531	Alcoholic Gastritis with Hemorrhage
53541	Other Specified Gastritis with Hemorrhage
53551	Unspecified Gastritis and Gastroduodenitis with Hemorrhage
53561	Duodenitis with Hemorrhage
5363	Gastroparesis
53640-53690	Gastrostomy Complications or Function of Stomach
5370	Acquired Hypertrophic Pyloric Stenosis
5373	Other Obstruction of Duodenum
5374	Fistula of Stomach or Duodenum
53783	Angiodyplasia of Stomach and Duodenum with Hemorrhage
53784	**Dieulofoy Lesion (Hemorrhagic) of Stomach and Duodenum**
54000-54090	Acute Appendicitis
54100-54190	Appendicitis, unspecified
542	Other Appendicitis
55000-55013	Inguinal Hernia with Gangrene or Obstruction
55100-55190	Other Abdominal Hernia with Gangrene
55200-55290	Femoral, Ventral or Other Hernia with Obstruction
55300-55390	Other Hernia of Abdominal Cavity without mention of Obstruction or Gangrene
55700-55790	Acute, Chronic or Other Vascular Insufficiency of Intestine
55810-55830	Gastroenteritis or Colitis due to Radiation or Toxins
56000-56090	Intestinal Obstruction without Hernia
56202	Diverticulosis of Small Intestine with Hemorrhage
56203	Diverticulitis of Small Intestine with Hemorrhage
56212	Diverticulosis of Colon with Hemorrhage
56213	Diverticulitis of Colon with Hemorrhage
566	Abscess of Anal and Rectal Region
56700-56790	Peritonitis
56881	Hemoperitoneum (nontraumatic)
5693	Hemorrhage of Rectum and Anus
5695	Abscess of Intestines
56960-56969	Colostomy and Enterostomy Complications
56981-**56986**	Other Specified Disorders of Intestine
570	Acute and Subacute Necrosis of Liver
57110	Acute Alcoholic Hepatitis
57200-57220	Abscess of Liver; Hepatic Coma
5734	Hepatic Infarct
57400-57580	Acute Cholelithiasis
57610-57630	Other Disorders of Biliary Tract

5770	Acute Pancreatitis
57800-57890	Gastrointestinal Hemorrhage
58000-58090	Acute Glomerulonephritis
58300-58390	Nephritis or Nephropathy
58450-58490	Acute Renal Failure
59010-59030	Acute Pyelonephritis
59080-59081	Other Pyonephrosis
59200-59290	Calculus of Kidney or Ureter
59381	VascularDisorder of Kidney
59382	Ureteral Fistual
59400-59490	Calculus of Lower Urinary Tract
5950	Acute Cystitis
59660-59670	Rupture or Hemorrhage of Bladder Wall
5970	Urethral Abscess
59910	Urethral Fistula
59950-59970	Prolapsed Urethral Mucosa; Urinary Obstruction, Unspecified; Hematuria
6010	Acute Prostatitis
60120-60190	Inflammatory Diseases of Prostate
6021	Congestion or Hemorrhage of Prostate
6031	Infected Hydrocele
6039	Hydrocele,unspecified
60400-60499	Orchiditis; Epididymitis
60710-60730	Balanoposthitis; Priapism; Other Inflammatory Disorders of Penis
60781-60783	Other Specified Disorders of Penis
6082	Torsion of Testes
60882	Hematospermia
60886	Edema of Penis
6140	Acute Salpingitis and Oophoritis
6143	Acute Parametritis and Pelvic Cellulitis
6145	Acute or Unspecified Pelvic Peritonitis (female)
6150	Acute Inflammatory Disease of Uterus, except cervix
6160	Cericitis and Endocervicitis
61630-61640	Abscess of Bartholon's Gland or Other Abcess of Vulva
62050-62070	Torsion of Ovary or Fallopian Tube; Hematoma or Laceration of Broad Ligament
6236	Vaginal Hematoma
6245	Hematoma of Vulva
6300	Hydatidiform Mole
63300-**63391**	Ectopic Pregnancy
63400-63492	Spontaneous Abortion
63500-63592	Legally Induced Abortion
63600-63692	Illegally Induced Abortion
63700-63782	Unspecified Abortion
63800-63882	Failed Attempted Abortion
63900-63990	Complications following Abortion or Ectopic or Molar Pregnancies
64000-64093	Hemorrhage in Early Pregnancy
64100-64193	Antepartum Hemorrhage; Placenta Previa; Abruptio Placentae
64200-64204	Hypertension Complicating Pregnancy; Childbirth; Puerperium
64210-64234	Hypertension Secondary to Renal Disease; Pre-existing or Transient
64240-64254	Mild, Severe, or Unspecified Pre-eclampsia

Diagnosis To Be Paid At Emergency Rate
By ICD-9-CM Code
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64260-64264	Eclampsia
64270-64274	Pre-eclampsia or Eclampsia Superimposed on Pre-Existing Hypertension
64290-64294	Unspecified Hypertension Complicating Pregnancy, Childbirth, or Puerperium
64310-64313	Hyperemesis Gravidarum with Metabolic Disturbance
64400-64413	Early or Threatened Labor
64420-64421	Early Onset of Delivery
64700-64784	Specific Infections Complicating Pregnancy
64800-64884	Specific Conditions Complicating Pregnancy
65000-65193	Normal Delivery; Twin, Triplet, Quadruplet, Other
65200-65393	Malposition and Malpresentation of Fetus
65400-65404	Congenital Abnormalities of Uterus
65410-65414	Tumors of Body of Uterus
65420-65423	Previous Cesarean Delivery
65430-65434	Retroverted and Incarcerated Gravid Uterus
65440-65444	Other Abnormalities of shape/position of Gravid Uterus or Neighboring Structures
65450-65494	Cervical Incompetence; Congenital or Acquired Abnormality of Cervix, Vagina,
65630-65633	Fetal Distress
65640-65643	Intrauterine Death
65810-65813	Premature Rupture of Membranes
65820-65823	Delayed Delivery after Spontaneous or Unspecified Rupture of Membranes
65830-65833	Delayed Delivery after Artificial Rupture of Membranes
65840-65843	Infection of Amniotic Cavity
65920-65923	Maternal Pyrexia during Labor, Unspecified
65930-65933	Generalized Infection during Labor
65970-65973	Abnormality in Fetal Heart Rate and Rhythm
66000-66093	Obstructed Labor
66100-66193	Abnormality of Forces of Labor
66200-66233	Prolonged Labor; First or Second Stage, unspecified
66300-66393	Umbilical Cord Complications
66400-66494	Trauma to Perineum and Vulva During Delivery
66500-66574	Other Obstetrical Trauma
66581-66584	Other Specified Obstetrical Trauma
66591-66594	Other Unspecified Obstetrical Trauma
66600-66714	Postpartum Hemorrhage and Other Postpartum Complications
66800-67004	Complications of Labor or Delivery
67100-67114	Venous Complications in Pregnancy and the Puerperium
67120-67154	Superficial; Deep Thrombophebitis, Other Phlebitis and Thrombosis
67180-67194	Other Venous Complications
67220-67224	Pyrexia of Unknown Origin During the Puerperium
67300-67384	Obstetrical Pulmonary Embolism
67400-67494	Other Complications of Pregnancy
67501-67594	Infection of Breast and Nipple Associated with childbirth
67620-67624	Engorgement of Breast
71610-71619	Traumatic Arthropathy
71700-71770	Internal Derangement of Knee
71820-71829	Pathological Dislocation of Joint
71860-71865	Unspecified Intrapelvic Protusion of Acetabulum
71910-71919	Hemarthrosis

72000-72020	Ankylosing Spondylitis and Other Inflammatory Spondylopathies
72750-72769	Rupture of Synovium or Tendon
7280	Infective Myositis
72811-72813	Muscular Calcification and Ossification
72881	Interstitial Myositis
73000-73009	Acute Osteomyelitis
73310-73319	Pathologic Fracture
73393-73395	Stress Fracture
74510-74511	Transposition of Great Vessels; Double Outlet Right Ventricle
74520-74550	Tetralogy of Fallot; Common Ventricle; Ventricular Septal Defect; Ostium Secumdum Type Atrial Septal Defect
74600-74670	Anomalies of Pulmonary Valve
74681-74699	Other Specified and Unspecified Anomalies of Heart
7470	Patent Ductus Arteriosus
74710-74711	Coarctation of Aorta (preductal) (postductal) or Interruption of Aortic Arch
75161	Biliary Atresia
76000-76390	Fetal or Newborn Complications in Perinatal Period
76400-76499	Slow Fetal Growth and Fetal Malnutrition
76500-**76529**	Disorders Relating to Short Gestation and Unspecified Low Birthweight
76600-76629	Disorders relating to Long Gestation and High Birthweight
76700-76790	Birth Trauma
76800-76890	Intrauterine Hypoxia; Birth Asphyxia
76900-76990	Respiratory Distress Syndrome in Newborn
77000-77090	Other Respiratory Conditions of Fetus or Newborn
77100-**77189**	Infections Specific to the Perinatal Period
77200-77299	Fetal and Neonatal Hemorrhage
77300-77350	Hemolytic Disease of Fetus or Newborn
77400-77470	Other Perinatal or Neonatal Jaundice
77500-77590	Endocrine and Metabolic Disturbances Specific to the Fetus and Newborn
77600-77690	Hematological Disorders of Fetus and Newborn
77710-77790	Perinatal Disorders of Digestive System
77800-77890	Conditions involving the Integument & Temperature Regulation of Fetus and Newborn
77900-77920	Convulsions, Cerebral Depression, Coma in Newborn
77940-77950	Drug Intoxication, Reaction, Withdrawal in Newborn
78000-78009	Coma And Stupor
7802	Syncope and Collapse
78031-78039	Convulsions
78100-78179	Symptoms Involving Nervous and Musculoskeletal Systems
7825	Cyanosis
7843	Aphasia
7848	Hemorrhage from Throat
78500-78510	Tachycardia, Unspecified; Palpitations
78540-78559	Gangrene; Shock without mention of Trauma
78603-78604	Apnea; Cheyne-Stokes Respiration
7861	Stridor
7863	Hemoptysis
78651	Percordial Pain
7880	Renal Colic
7887	Urethral Discharge
7907	Bacteremia

79200-79239	Nonspecified Abnormal Findings in other Body Substance or Body Structure
79800-79890	Sudden Death, cause unknown
7990	Asphyxia
7991	Respiratory Arrest
80000-83990	Fractures and Dislocations, various sites
84000-84519	Sprains and Strains, various sites
85000-89770	Skull Injuries; Internal Injuries; Open Wounds of various sites
90000-90490	Injuries to Blood Vessels
91800-91890	Superficial Injury of Eye and Adnexa
92000-92190	Contusions of Face or Head
92510-95990	Crushing Injuries; Foreign Bodies; Burns; Spinal Injuries
96000-99510	Poisoning; Toxic Effects of Substances
99530-99570	Other Effects of External Causes
99580-99890	Mechanical Complications and Other Complications of External Causes
V460	Aspirator (dependence on machine)
V461	Respirator (dependence on machines)
V462	**Other Dependence on Machine**
V468	Other Enabling Machine
V6121	Child Abuse
V6122	Counseling for Perpetrator of Parental Child Abuse
V714	Observation following other accident (MVA)
V715	Observation following alleged rape or seduction
V716	Observation following other inflicted injury
V7181	Observation for Abuse and Neglect
V7182	**Observation and Evaluation for Suspect Anthrax Exposure**
V7183	**Observation and Evaluation for Suspect Other Biological Exposure**
E8000-E9590	All will pay within this range
E9601-E9689	All will pay within this range
E9700-E9980	All will pay within this range

0408	Other Specified Bacterial Disease
04100-04109	Streptoccus Unspecified; Groups A, B, C, D, G and Other
04110-04200	Staphylococcus; Penmococcus; Other Specified Bacterial Infections
0460-0469	Slow Virus Infection of Central Nervous System
0510-0519	Cowpox; Pseudocowpox; Paravaccinia; Unspecified
0540	Eczema Herpeticum
0552	Postmeasle Otitis Media
05579-05590	Other Measles with and without complications
05700-05790	Other Viral Exanthemata
0669	Arthropod-borne Viral Diseases; Unspecified
0709	Unspecified Viral Hepatitis without hepatic coma
0743-0769	Hand; Foot; Mouth Disease; Other Specified Disease due to Coxsackie Virus; Trachoma
0770-0773	Other Disease of Conjunctiva due to Viruses and Chlamydia
0778-0785	Other Viral Conjunctivitis; Other Specified; and Unspecified Diseases due to Viruses and Chlamydiae
07881-07889	Other Specified Diseases due to Coxsackie Virus
07900-07959	Viral and Chlamydial Infections in conditions classified elsewhere and of Unspecified Site; Retrovirus
07981-07989	Other Specified Viral and Chlamydial Infections
07998-07999	Unspecified Viral and Chlamydial Infections in Conditions classified elsewhere and Site Unspecified
0982	Gonococcal Infection; Chronic, of Lower Genitourinary Tract
09830-09839	Gonococcal; Chronic, of Upper Genitourinary Tract
10089	Leptospiral; Other
10090	Leptospirosis, Unspecified
101	Vincent's Angina
10200-10290	Yaws
10300-10390	Pinta
10400-10490	Other Spirochetal Infections
11000-11090	Dermatophytosis
11100-11190	Dermatophytosis; Other and Unspecified
11200-11230	Candidiasis
1125	Disseminated Candidiasis
11289-11290	Other Candidiasis and of Unspecified Sites
11400-11410	Primary; Extrapulmonary; Other Coccidioidomycosis
11430-11490	Other Forms of Coccidioidomycosis; Unspecified Primary or Pulmonary Coccidioidomycosis
11500	Histoplasmosis without mention of manifestation
11509	Other Histoplasmosis without mention of manifestation
11510	Infection by Histoplasma Duboisii without mention of manifestation
11519	Other Infection by Histoplasma Duboisii
11590	Histoplasmosis; Unspecified without mention of manifestation
11599	Other Histoplasmosis
11600-11620	Blastomycotic; Paracoccidiodomucosis; Lobomycosis
11700-11800	Other Mycoses; Infection by Dematiacious Fungi (Phaehyphomycosis); Opportunistic; Unspecified and Other Mycoses
12000-12090	Schistos iasis (bilharziasis)
12100-12190	Other Trematode Infection

12200-12290	Echinococcosis
12300-12390	Other Cestode Infection
124	Trichinosis
12500-12590	Filarial Infection and Dracontiasis
12600-12690	Ancylostomiasis and Necatoriasis
12700-12790	Other Intestinal Helminthiases
12800-12890	Other and Unspecified Helminthiases
129	Intestinal Parasitism, Unspecified
13100-13390	Trichomoniasis; Pediculosis and Phthirus Infection; Acariasis
13400-13620	Other Infestations; Other and Unspecified Infectious and Parasitic Diseases
13640-13690	Other and Unspecified Infectious and Parasitic Diseases
13700-13800	Late Effects of Tuberculosis
13900-13980	Late Effects of Other Infectious and Parasitic Disease
14000-14490	Malignant Neoplasm of Lip; Tongue; Major Salivary Gland; Gum; Floor of Mouth
14500-14990	Malignant Neoplasm of Other and Unspecified Parts of Mouth; Oropharynx; Nasopharynx; Hypopharynx; and Other Ill-Defined Sites of Lip, Oral Cavity and Pharynx
15000-15480	Malignant Neoplasm of Esophagus; Stomach; Small Intestine including Duodenum, Colon, Rectum, Rectosigmoid Junction, and Anus
15500-15990	Malignant Neoplasm of Liver, Intrahepatic Bile Ducts, Gallbladder, Extrahepatic Bile Ducts, Pancreas, Retroperitoneum and Other Ill Defined Sites of the Digestive Organs and Peritoneum
16000-16590	Malignant Neoplasm of Nasal Cavities, Larynx, Trachea, Bronchus, Lung, Pleura, Thymus, Heart, Mediastinum, Upper Respiratory Tract, part unspecified
17000-17390	Malignant Neoplasm of Bone; Articular Cartilage; Connective and Soft Tissue, Skin and Other Malignant Neoplasm of Skin
17400-17900	Malignant Neoplasm of Female and Male Breast; Kaposi's Sarcoma; Uterus, parts unspecified
18000-18790	Malignant Neoplasm of Cervix Uteri, Uterus, Ovary and Other Uterine Adnexa; Other and Unspecifed Female Genital Organs, Testis, Penis and Other Male Genital Organs
18800-18990	Malignant Neoplasm of Bladder, Kidney and Other Unspecified Urinary Organs
19000-19390	Malignant Neoplasm of Eyeball, Brain, Other and Unspecified Parts of Nervous System
19400-19690	Malignant Neoplasm of Other Endocrine Glands and Related Structure, Ill-Defined Sites
19700-19780	Secondary and Unspecified Malignant Neoplasm of Lymph Nodes, Respiratory and Digestive System
19800-19910	Secondary Malignant Neoplasm of Other Specified Sites; without Specified Sites
20000-20088	Lymphosarcoma; Reticilosarcoma; Burkitt's Tumor; Other Named Variants
20100-20148	Hodgkin's Disease, Hodgkin's Granuloma, Hodgkin's Sarcoma, Lymphocytic-Histiocytic Predominance
20150-20198	Nodular Sarcoma, Mixed Cellularity, Lymphocytic Depletion, Hodgkin's Disease- Unspecified
20200-20238	Nodular Lymphoma; Mycosis Fungoides; Sezary's Disease; Malignant Histiocytosis

20240-20268	Leukemic Reticuloendotheliosis; Letter-Siwe Disease; Malignant Mast Cell Tumors
20280-20288	Other Lymphomas
20290-20298	Other and Unspecified Malignant Neoplasms of Lympoid, Histiocytic Tissue
20300-20311	Multiple Myeloma, Plasma Cell Leukemia
20380-20381	Other Immunoproliferative Neoplasms
20400-20411	Acute or Chronic Lymphoid Leukemia
20420-20421	Subacute Leukemia
20480-20491	Other and Unspecified Lymphoid Leukemia
20500-20531	Myeloid Leukemia, Chronic or Subacute; Myeloid Sarcoma
20580-20591	Other and Unspecified Myeloid Leukemia
20600-20621	Acute Monocytic Leukemia, Chronic, Subacute
20680-20691	Other and Unspecified Monocuutic Leukemia
20700-20721	Other Specified Leukemia; Chronic Erythemia
20780-20891	Megakaryicytic Leukemia; Leukemia of Unknown Cell Type; Other and Unspecified Leukemia of Unknown Cell Types
21000-21390	Benign Neoplasm of Lip, Oral Cavity, Pharynx; Other Parts of Digestive System, Respiratory, Intrathoracic Organs, Bone and Cartilage
21400-22290	Lipoma, Benign Neoplasm of Connective, Other Soft Tissue, Skin, Uterine Leiomyoma, Uterus, Other Female Genital Organs, Other Male Genital Organs
22300-22799	Benign Neoplasm of Kidney, Other Urinary Organs, Other Specified Sites of Urinary Organs, Eye, Brain, Other Parts of Nervous System, Other Endocrine Glands and Related Structures
22800-22990	Hemangioma, Lymphangioma, Any Site, Benign Neoplasm of Other and Unspecified Sites
23000-23490	Carcinoma in Situ of Digestive Organs, Respiratory System, Skin, Breast, Genitourinary System, Other and Unspecified Sites
23500-23760	Neoplasms of Uncertain Behavior of Digestive System, Respiratory System, Genitourinary Organs, Unspecified Urinary Organs, Endocrine Glands and Nervous System
23770-23790	Neurofibromatosis
23800-23990	Neoplasms of Uncertain Behavior of Other and Unspecified Sites and Tissues, Other Unspecified Nature
24000-24090	Goiter, Specified as Simple or Unspecified
24100-24190	Nontoxic Nodular Goiter
24300-24490	Congential or Aquired Hypothroidism
24510-24590	Subacute, Chronic, Other and Unspecified Thyroiditis
24600-24620	Other Disorders of Thyroid
24680-24690	Other Specified and Unspecified Disorders of Thyroid
25000-25001	Diabetes Mellitus without mention of Complications, Type I and II, controlled
25040-25041	Diabetes Mellitus with Renal Manifestations, Type I and II, controlled
25050-25051	Diabetes Mellitus with Ophthalamic Manifestations, Type I and II, controlled
25060-25061	Diabetes Mellitus with Neurological Manifestations, Type I and II, controlled
25070-25071	Diabetes Mellitus with Peripheral Circulatory Disturbances, Type I and II, controlled
25080-25081	Diabetes Mellitus with Other Specified Manifestations, Type I and II, controlled

25090-25091	Diabetes Mellitus with Other Unspecified Complications, Type I and II, controlled
25130-25190	Postsurgical Hypoinsulinemia, Abnormality of Secretions of Glucagon or Gastrin, Other Specified and Unspecified Pancreatic Internal Secretion
2520	Hyperparathyroidism
25280-25290	Other Specified and Unspecified Disorders of Parathyroid Gland
25300-25340	Acromegaly, Giantism, Panhypopituitarism, Pituitary Dwarfism, Other Unspecified and Specified Anterior Pituitary Hyperfunction
25360-25390	Other Disorders of Neurohypophysis, Iatrogenic Pituitary Disorders, Other Syndrome of Diecephalohhypophyseal Origin, Unspecified Disorders of Pituitary
2540-25490	Diseases of Thymus Gland
25500-25530	Cushing's Syndrome, Hyperaldosteronism, Adrenogenital Disorders, Other Corticoadrenal Overactivity
25550-25590	Other Adrenal Dysfunction, Other Specified and Unspecified Disorders of Adrenal Gland
25600-25690	Ovarian Dysfunction
25700-25790	Testricular Hyperfunction
25800-25890	Polygandular Dysfunction and Related Disorders
25900-26100	Other Endocrine Disorders
26300-26390	Other and Unspecified Protein-Calorie Malnutrition
26400-26990	Vitamin A, Thiamine, Niacin, B-Complex Components, Vitamin D, Other Nutritional Deficiencies
27000-27190	Disturbance of Amino-Acid Transport, Disorder of Carbohydrate Transport and Metabolism
27200-27390	Disorders of Lipoid, Plasma Protein Metabolism
27410-27490	Other and Unspecified Gouty Neuropathy, Uric Acid Nephrolithiasis, Gouty Tophi of ear and other sites, Specified or Unspecified Manifestations
27500-27540	Disorders of Mineral or Calcium Metabolism
27549-27590	Other and Specified Disorders of Mineral Metabolism
2769	Electrolytes and Fluid Disorders not elsewhere classified
27700-27790	Cystic Fibrosis; Other and Unspecified Disorders of Metabolism
27800-27880	Obesity and Other Hyperalimentation
27900-27990	Deficiency of Humoral Immunity, Disorders of Deficiency of Cell-Mediated Immunity
28000-28250	Iron Deficiency Anemias, Other Deficiency Anemias, Hereditary Hemolytic Anemias
28260-28261	Sickle Anemia, Unspecified; Hb-S Disease without mention of crisis
28263-28310	Sickle Cell/Hb-C Disease; Other Specified Heredity Hemolytic Anemias, Autoimmune and Non-autoimmune Hemolytic Anemias
28319-28500	Other Non-Autoimmune Hemolytic Anemais; Hemoglobinuria due to Hemolysis from External Cause; Acquired Hemolytic Anemias; Aplastice Anemias; Seroblastic Anemia
28521-28590	Other Specified and Unspecified Anemias
28800-28890	Diseases of White Blood Count
28900-28940	Polycythemia, Secondary; Chronic Lymphadenitis; Nonspecific Mesenteric Lymphadenitis; Hypersplenism
28950-28970	Diseases of Spleen, Unspecified; Chronic Congestive Splenomegaly; Familial Polycthemia; Other Diseases of Spleen

28980-28990	Other Specified and Unspecified Diseases of the Blood and Blood Forming Organs
2900	Senile Dementia
29010	Presentile Dementia
29012-29013	Presentile Dementia with Delusional or Depressive Features
29020-29021	Senile Dementia with Delusional or Depressive Features
29040	Atheriosclerotic Dementia, Uncomplicated
29042-29090	Atheriosclerotic Dementia with Delusional or Depressive Features; Uncomplicated; Unspecified Senile Psychotic Condition
2911	Alcohol Amnestic Syndrome
2912	Other Alcoholic Dementia
2914	Idiosyncratic Alcohol Intoxication
2915	Alcoholic Jealousy
29189-29190	Other Specified Alcoholic Psychosis
2920	Drug Withdrawal Syndrome
29211	Drug Induced-Organic Delusional Syndrome
2922	Pathological Drug Intoxication
29282-29290	Drug Induced Dementia; Drug Induced Amnestic Syndrome; Other Specified Drug Induced Mental Disorders; Other Organic Psychotic Conditions (chronic)
2931	Transient Organic Psychotic Conditions-Subacute
29381-29390	Other Specified Transient Organic Mental Disorders; Unspecified Transient Organic Mental Disorders
2940	Amnestic Syndrome
29410-29490	Other Organic Psychotic Conditions (chronic)
29500-29502	Schizophrenic Disorder-Simple Type Chronic
29505	Schizophrenic Disorder-Simple Type in Remission
29510-29512	Schizophrenic Disorder-Disorganized Type; Unspecified; Subchronic; Chronic
29515	Schizophrenic Disorder-Disorganized Type in remission
29520-29522	Schizophrenic Disorder-Catatonic Type; Unspecified; Subchronic; Chronic
29525	Schizophrenic Disorder-Catatonic Type in remission
29530-29532	Schizophrenic Disorder-Paranoid Type; Unspecified; Subchronic; Chronic
29535	Schizophrenic Disorder-Paranoid Type in remission
29540-29542	Acute Schizophrenic Episode; Unspecified; Subchronic; Chronic
29545	Acute Schizophrenic Episode in remission
29550-29552	Latent Schizophrenic-Unspecified; Subchronic; Chronic
29555	Latent Schizophrenic in remission
29560-29562	Residual Schizophrenic; Unspecified; Subchronic; Chronic
29565	Residual Schizophrenic in remission
29570-29572	Schizophrenic Disorder-Schizo-Affective Type; Unspecified; Subchronic; Chronic
29575	Schizophrenic Disorder-Schizo-Affective Type in remission
29580-29582	Other Specified Types of Schizophrenic; Unspecified; Subchronic; Chronic
29585	Other Specified Types of Schizophrenic in remission
29590-29592	Unspecified Schizophrenic; Unspecified; Subchronic; Chronic
29595	Unspecified Schizophrenic in remission
29600-29602	Affective Psychoses-Manic Disorder-Single Episode; Unspecified; Mild; Moderate
29605-29606	Affective Psychoses-Manic Disorder-Single Episode;

	Unspecified; Mild, Moderate; in Partial; Unspecified Remission
29610-29612	Affective Psychoses-Manic Disorder-Recurrent Episode; Unspecified; Mild; Moderate
29615-29616	Affective Psychoses-Manic Disorder-Recurrent Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29620-29622	Affective Psychoses-Major Depression Disorder-Single Episode; Unspecified; Mild; Moderate
29625-29626	Affective Psychoses-Major Depression Disorder-Single Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29630-29632	Affective Psychoses-Major Depression Disorder-Recurrent Episode; Unspecified; Mild; Moderate
29635-29636	Affective Psychoses-Major Depression Disorder-Recurrent Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29640-29642	Affective Psychoses-Bipolar Affective Disorder-Manic; Unspecified; Mild; Moderate
29645-29646	Affective Psychoses-Bipolar Affective Disorder-Manic; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29650-29652	Affective Psychoses-Bipolar Affective Disorder-Depressed; Unspecified; Mild; Moderate
29655-29656	Affective Psychoses-Bipolar Affective Disorder-Depressed; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29660-29662	Affective Psychoses-Bipolar Affective Disorder-Mixed; Unspecified; Mild; Moderate
29665-29670	Affective Psychoses-Bipolar Affective Disorder-Mixed; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29680-29699	Manic Depressive Psychosis
29700-29790	Paranoia; Paraphrenia; Shared Paranoid Disorder; Other Specified or Unspecified Paranoid Disorder
29800-29890	Other Non-organic Psychosis
29900-29991	Psychoses with Origin Specific to Childhood
30000-30009	Anxiety States
30010-30019	Hysteria, Unspecified; Other and Unspecified Fictitious Illness
30020-30090	Phobia Disorders; Other Neurotic Disorders
30100-30170	Personality, Affective Personality, Schizoid Personality, Histrionic Personality Disorders
30181-30290	Other Personality Disorders; Sexual Deviations and Disorders; Trans-sexualism; Psychosexual Dsyfunction; Other Specified Psychosexual Disorders
30300-30393	Alcohol Dependence Syndrome; Other or Unspecified Alcohol Dependence
30400-30453	Opioid Type; Barbiturate and Similarly Acting Sedative or Hypnotic; Cocaine; Cannabis; Amphetamine and Other Psychostimulant; Hallucinogen Dependence
30460-30493	Other Specified Drug; Combinations of Opioid Type with Any Other; Combinations of Drug Dependence excluding Opioid Type Dependence
30500-30543	Alcohol Abuse; Tobacco Use Disorder; Cannibis Abuse; Hallucinogen Abuse; Barbiturate and Similarly Acting Sedative or Hypnotic Abuse
30550-30593	Opioid Abuse; Cocaine Abuse; Amphetamine or Related Acting Sympathomimetic Abuse; Antidepressant Type Abuse; Other, Mixed, or Unspecified Drug Abuse
30600-30690	Physiological Malfunction /arising from Mental Factors;

	Psychogenic Genitourinary Malfunction
30700-30790	Special Symptoms or Syndromes, not elsewhere classified; Tics; Sterotyped Repetitive Movements; Specific Disorders of Sleep of Nonorganic Origin; Psychalgia
30800-30990	Acute Reaction to Stress; Adjustment Reaction and with Predominant Disturbance of Other Emotions; Other Specified Adjustment Reaction
31000-31110	Frontal Lobe Syndrome; Organic Personality Syndrome; Other Specified and Unspecified Non-psychotic Mental Disorders due to Organic Brain Damage; Disturbance of Conduct
31200-31239	Undersocialized Conduct Disorder, Aggressive and Unaggressive Type; Socialized Conduct Disorder; Disorders of Impulse Control, not elsewhere classified
3124	Mixed Disturbance of Conduct and Emotions
31281-31310	Other Specified Disturbances of Conduct, not elsewhere classified; Disturbances of Emotions Specific to Childhood or Adolescence-Overanxious Disorder
31321-31490	Sensitivity, Shyness and Social Withdrawal Disorder; Other or Mixed Emotional Disturbances of Childhood or Adolescence; Attention Deficit Disorder
31500-31790	Specific Reading Disorder; Developmental Speech or Language Disorder
31800-31990	Other Specified Mental Retardation
33000-33170	Cerbral Degenerations Usually Manifest in Childhood; Other Cerebral Degeneration
33181-33190	Reye's Syndrome; Other and Unspecified Cerebral Degeneration
33200-33370	Parkinson's Disease; Other Extrapyramidal Disease and Abnormal Movement Disorder
33381-33382	Blepharospasm; Orofacial Dyskinesia
33384-33389	Organic Writer's Cramp; Other Fragments of Torsion Dystonia
33390-33391	Unspecified Extrapyramidal Disease and Abnormal Movement Disorder; Stiff-man Syndrome
33393-33399	Benign Shuddering Attacks; Other and Unspecified Extrapyramidal Diseases and Abnormal Movement Disorder
33400-33420	Friedreich's Ataxia; Hereditary Spastic Paraplegia; Primary Cerebellar Degeneration; Primary Cerebellar Degeneration
33440-33590	Cerbebellar Ataxia in Diseases classified elsewhere; Other and Unspecified Spinocerebellar Diseases; Anterior Horn Cell Diseases; Spinal Muscular Atrophy; Motor Neuron Disease
3360	Syringomyelia and Syringobulbia
33620-33690	Subacute Combined Degeneration of Spinal Cord in Diseases classified elsewhere; Myelopathy in other Diseases Classified Elsewhere; Other Myelopathy; Unspecified Diseases of Spinal Cord
33700-34190	Disorders of Autonomic Nervous System; Reflex Sympathetic Dystrophy; Other Demyelinating Diseases of Central Nervous System
34200-34390	Hemiplegia; Hemiparesis; Other Paralytic Syndromes
34400-34490	Quadriplegia; Quadriparesis; Monoplegia of Upper and Lower Limb; Cauda Equina Syndrome; Other Specified Paralytic Syndromes
34500-34510	Generalized Convulsive or Non-Convulsive Epilepsy
345450-34551	Partial Epilepsy with Impairment of Consciousness
34560	Infantile Spasms, with Intractable Epilepsy

34570	Epilepsia Partialis Continus
34580	Other Forms of Epilepsy, with Intractable Epilepsy
34590	Epilepsy, Unspecified
34600	Classic Migraine
34610	Common Migraine
34620	Variants Migraine
34680	Other Forms Migraine
34690	Unspecified Migraine
347	Cataplexy and Narcolepsy
3480	Cerebral Cysts
3482	Benign Intracranial Hypertension
34880-34890	Other and Unspecified Conditions of Brain
3492	Disorders of Meninges, not elsewhere classified
34989-34990	Other and Unspecified Disorders of Nervous System
3502	Atypical Face Pain
3508	Other Trigeminal Nerve Disorders
3509	Unspecified Trigeminal Nerve Disorders
3511	Geniculate Ganglionitis
3518	Other Facial Nerve Disorders
3519	Unspecified Facial Nerve Disorders
35200-35390	Disorders of Other Cranial Nerves; Nerve Root and Plexus Disorders
35400-35590	Mononeuritis of Upper Limb and Mononeuritis Multiplex; Mononeuritis of Lower Limb-Lesion of Sciatic Nerve; Other Mononeuritis of Lower Limb
35600-35690	Hereditary and Idopathic Neuropathy
35710-35790	Inflammatory and Toxic Neuropathy
35810-35890	Myasthenic Syndrome in Disease Classified Elsewhere, Toxic Myoneural Disorders; Other Specified and Unspecified Myoneural Disorders
35900-35990	Congenital and Progressive Hereditary Muscular Dystrophy Myotonic Disorders; Myopathy in Endocrine Diseases classified elsewhere; Symptomatic Inflammatory Myopathy in Diseases Classified Elsewhere; Other and Unspecified Myopathies
36020-36044	Degenerative Disorder of Globe; Hypotony of Eye; Degenerated Globe or Eye
36050-36090	Retained (old), Intraocular Foreign Body, Magnetic and Nonmagnetic; Other Disorders of Globe
36106-36107	Old Retained Detachment, Partial, Total, Subtotal
36110-36119	Retinoschisis and Retinal Cysts
36130-36133	Retinal Defect without detachment
36201-36229	Diabetic Retinopathy; Other Background Retinopathy and Retinal Vascular Changes; Other Proliferative Retinopathy
36250-36277	Degeneration of Macula and Posterior Pole; Peripheral Retinal Degeneration
36282-36290	Hereditary Retinal Dsytrophies; Other Retinal Disorders; Unspecified Retinal Disorders
36300-36322	Focal Chorioretinitis and Focal Retinochorioretinitis; Disseminated Chorioretinitis and Disseminated Retinchoroiditis; Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis
36330-36357	Chorioretinal Scars; Choroid Degeneration; Hereditary Choroid Dystrophies
36380-36390	Other and Unspecified Disorder of Choroid

36410-36411	Chronic Iridocyclitis, Unspecified or in Diseases classified elsewhere
36442	Rubeosis Iridis
36451-36490	Degeneration of Iris and Ciliary Body; Cysts of Iris, Ciliary Body, Anterior Chamber; Adhesions and Disruptions of Iris and Ciliary Body
36500-36503	Borderline Glaucoma (glaucoma suspect)
36510-36521	Open-angle Glaucoma; Primary Angle-closure Glaucoma
36523-36524	Chronic Angle-closure Glaucoma; Residual Stage of Angle-closure Glaucoma
36531-36564	Corticosteroid-induced Glaucoma; Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes; Glaucoma Associated with Disorders of Lens; Glaucoma Associated with Other Ocular Disorders
36581-36690	Other Specified Forms of Glaucoms; Infantile, Juvenile, Presenile, Senile, Traumatic Cataracts; Cataract Secondary to Ocular Disorders; Cataract Associated with Other Disorders; After-Cataract
36700-36790	Disorders of Refraction and Accommodation; Astigmatism; Anisometropia and Aniselkonia; Disorders of Accommodation; Other Disorders of Refraction and Accommodation
36800-36810	Amblyopia Ex Anopsia; Subjective Visual Disturbances, Unspecified
36813-36820	Visual Discomfort; Visual Distortions and Entoptic Phenomena; Psychophysical Visual Disturbances; Diplopia
36830-36890	Other Disorders or Binocular Vision; Visual Field Defects; Color Vision Deficiencies; Night Blindness
36900-36990	Profound Impairment, Both Eyes; Moderate or Severe Impairment, Better eye, Profound Impairment Lesser Eye; Moderate or Severe Impairment, Both Eyes; Profound Impairment, One Eye; Moderate or Severe Impairment, One Eye
37001-37002	Marginal Corneal Ulcer; Ring Corneal Ulcer
37004-37005	Mycotic or Perforated Corneal Ulcer
37007	Mooren's Ulcer
37031-37035	Certain Types of Keratoconjunctivitis
37049	Other Keratoconjunctivitis
37060-37116	Corneal Neovascularization; Corneal Scars and Opacities; Corneal Pigmentation and Deposits
37130-37190	Changes of Corneal Membranes; Corneal Degenerations; Hereditary Corneal Dystrophies; Keratoconus; Other Corneal Deformities; Other Corneal Disorders
37203-37204	Other Mucopurulent; Pseudomembranous Conjunctivitis
37210-37215	Chronic Conjunctivitis
37230-37231	Conjunctivitis, Unspecified; Rosacea Conjunctivitis
37239	Other Conjunctivitis
37240-37264	Pterygium; Conjunctival Degenerations and Deposits; Conjunctival Scars
37274-37290	VascularAbnormalities of Conjunctiva; Conjunctiva Cysts; Other and Unspecified Disorders of Conjunctiva
37300	Blepharitis, Unspecified
3732	Chalazion
37331-37390	Eczematous Dermatitis of Eyelid; Noninfectious Dermatoses of Eyelid

37400-37446	Entropian and Trichiasis of Eyelid; Ectropion; Lagophthalmos; Ptosis of Eyelid; Other Disorders Affecting Eyelid Function
37450-37456	Degenerative Disorders of Eyelid and Periocular Area
37482-37485	Hemorrhage, Edema, Elephantiasis, Cysts, Vascular Anomalies
37487-37490	Dermatochalasis of Eyelid; Other and Unspecified Disorders of Eyelid
37502-37503	Chronic Dacryoadenitis; Chronic Enlargement of Lacrimal Gland
37511-37522	Other Disorders of Lacrimal Gland; Epiphora
37541-37590	Chronic Inflammation of Lacrimal Passages; Stenosis and Insufficiency of Lacrimal Passages; Other Changes of Lacrimal Passages; Other Disorders of Lacrimal System
37610-37613	Chronic Inflammatory Disorders of Orbit
37621-37622	Endocrine Exophthalmos
37630-37631	Exophthalmos, Unspecified; Constant Exophthalmos
37640-37647	Deformity of Orbit
37650-37652	Enophthalmos, Unspecified as to cause; Enophthalmos due to Atrophy of Orbital Tissue, Trauma or Surgery
3766	Retained (old) Foreign Body
37681-37690	Other Orbital Disorders
37700	Papilledema, Unspecified
37702-37724	Papilledema Associated with Increase Intracranial Pressure, Decreased Ocular Pressure, with Retinal Disorder; Foster-Kennedy Syndrome; Optic Atrophy; Other Disorders of Optic Disc
37730-37731	Optic Neuritis, Unspecified; Optic Papillitis
37733-37739	Nutritional Optic Neuropathy; Toxic Optic Neuropathy; Other
37751-37845	Disorders of Optic Chiasm; Disorders of Other Visual Pathways; Disorders of Visual Cortex; Esotropia; Exotropia; Intermittent Heterotropia; Other and Unspecified Heterotropia; Heterophoria
37850	Paralytic Strabismus
37855-37856	External or Total Ophthalmoplegia
37860-37919	Mechanical Strabismus; Other Specified Strabismus; Other disorders of Binocular Eye Movements; Scieritis and Episcleritis; Other Diseases of Sclera
37921-37922	Vitreous Degeneration; Crystalline Deposits in Viterous
37924-37925	Other Vitreous Opacities
37929	Other Disorders of Vitreous
37931	Aphakia
37939	Other Disorders of Lens
37940-37999	Dissocated Nystagmus; Other Forms of Nystagmus; Deficiencies of Saccadic Eye or Smooth Pursuit Movement; Other Irregularities of Eye Movement; Other Specified Disorders of Eye and Adnexa
38000	Perichondritis of Pinna, unspecified
38002	Perichondritis of Pinna, chronic
38015-38016	Chronic Muycotic Otitis Externa; Other Chronic Infective Otitis Externa
38021	Cholesteatoma of External Ear
38023	Other Chronic Otitis Externa
38030	Disorder of Pinna, unspecified
38032	Acquired Deformities of Auricle or Pinna
38039	Other Acquired Deformities of Auricle or Pinna
3804	Impacted Cerumen
38050-38053	Acquired Stenosis of External Ear Canal

38081-38090	Other Disorders of External Ear
38100-38190	Acute or Chronic Serous Otitis Media; Chronic Mucoid Otitis Media; Eustachian Salpingitis; Obstruction of Eustachian Tube; Other Disorders of Eustachian Tube
38210-38290	Chronic Tubotympanic or Atticoantral Suppurative Otitis Media; Unspecified or Unspecified Chronic Suppurative Otitis Media; Unspecified Otitis Media
3831	Chronic Mastoiditis
38320-38390	Petrositis; Complications Following Mastoidectomy; Other Disorders of Mastoid
38409-38410	Chronic or Other Myringitis without mention of Otitis Media
38481-38519	Other Specified Disorders of Tympanic Membrane; Other Disorders of Middle Ear and Mastoid; Tympanosclerosis; Adhesive Middle Ear Disease
38521-38524	Impaired Mobility of Malleus or Other Ear Ossicles; Partial Loss or Necrosis of Ear Ossicles
38530-38535	Cholesteatoma of Middle Ear and Mastoid
38582	Cholesterin Granuloma
38589-38590	Other and Unspecified Disorder of Middle Ear and Mastoid
38604	Inactive Meniere's Disease
38640-38802	Labyrinthine Fistula; Labyrinthine Dysfunction; Otosclerosis; Degenerative and Vascular Disorders of Ear
38810	Noise effects on Inner Ear, unspecified
38830-38850	Tinnitus; Other Abnormal Auditory Perception
38860	Otorrhea, Unspecified
38869	Presbyacusis
38872	Otalgia, Referred Pain
3888	Other Disorders of Ear
3889	Unspecified Disorders of Ear
38900-38908	Conductive Hearing Loss, Unspecified or External Ear
38910-38990	Sensorineural Hearing Loss, Unspecified; Sensory Hearing Loss
39000-39001	Rheumatic Fever without mention of heart involvement
39200-39890	Rheumatic Chorea; Diseases of Mitral Valve; Diseases of Aortic Valve; Diseases of Mitral and Aortic Valves; Diseases of Other Endocardial Structures
39899	Other Rheumatic Heart Disease
40110- 40190	Essential Hypertension
40210	Benign Hypertensive Heart Disease without congestive heart failure
40290	Unspecified Hypertensive Heart Disease without congestive heart failure
40300	Malignant Hypertensive Renal Disease without mention of renal disease
40310	Benign Hypertensive Renal Disease without mention of renal disease
40390	Unspecified Hypertensive Renal Disease without mention of renal failure
40410	Benign Hypertensive Heart and Renal Disease without mention of CHF or renal failure
40490	Unspecified Hypertensive Heart and Renal Disease without mention of CHF or renal failure
40509	Malignant and Other Secondary Hypertension
40511-40519	Benign Secondary Hypertension
40591-40599	Unspecified Secondary Hypertension

41200-41201	Old Myocardial Infarction
41400-**41406**	Coronary Atherosclerosis
41419-41490	Other Specified or Unspecified Forms of Chronic Ischemic Heart Disease
41600-41790	Chronic Pulmonary Heart Disease; Other Diseases of Pulmonary Circulation
42400-42430	Other Diseases of Endocardium
42500-42590	Cardiomyopathy
42820	**Systolic Heart Failure, Unspecified**
42822	**Systolic Heart Failure, Chronic**
42830	**Diastolic Heart Failure, Chronic**
42832	**Diastolic Heart Failure, Unspecified**
42840	**Combined Diastolic and Systolic Heart Failure, Unspecified**
42842	**Combined Diastolic and Systolic Heart Failure,Chronic**
42910-42930	Myocardial Degeneration; Unspecified Cardiovascular Diseases; Cardiomegaly
42981-42990	Other Ill Defined Heart Diseases
43700-43710	Cerebral Atherosclerosis; Other Generalized Ischemic Cerebrovascular Disease
4374	Cerebral Arteritis
4375	Moyamoya Disease
43780-43790	Other and Unspecified Ill-Defined Cerebrovascular Disease
43800-43890	Late Effects of Cerebrovascular Disease; Speech and Language Deficits; Hemiplegia, Hemiparesis; Monoplegia of Upper or Lower Limb; Other Paralytic Syndrome; Other Late Effects of Cerebrovascular Disease
44000-44029	Atherosclerosis of Aorta; Renal Artery; Native Arteries of Extremities; Unspecified Atherisclerosis of Extremities
44030-44090	Artherosclerosis of Bypass Graft of Extremities
44300-44319	**Other Peripheral Vascular Disease**
44380-44390	**Other Specified Peripheral Vascular Disease**
44800-44890	Diseases of Capillaries
45400-45490	Varicose Veins of Lower Extremities
45500-45590	Hemorroids
4561	Esophageal Varcies without mention of bleeding
45621-45680	Esophageal Varices in Diseases classified elsewhere
45780-45790	Other and Unspecified Noninfectious Disorders of Lymphatic Channels
4581	Chronic Hypertension
4589	Hypotension, Unspecified
45910-45920	Other Diseases of Circulatory System
45930-45939	**Chronic Venous Hypertension**
45981-46000	Other Specified Disorders of Circulatory System; Acute Nasopharyngitis (common cold)
46100-46410	Acute Sinusitis; Acute Laryngitis and Tracheitis
46420	Acute Laryngotracheitis
46450	Supraglottitis without Obstruction
46500-46590	Acute Upper Respiratory Infections of multiple or unspecified sites
4660	Acute Bronchitis
470	Deviated Nasal Septum
47100-47490	Nasal Polyps; Chronic Pharyngitis and Nasophayngitis; Chronic Sinusitis; Chronic Tonsillitis and Adenoiditis

47600-47810	Chronic Laryngitis and Laryngotracheitis; Allergic Rhinitis; Other Diseases of Upper Respiratory Tract
47820	Unspecified Diseases of Pharynx
47826	Cyst of Pharynx or Nasophaynx
47829	Other Disease of Pharynx
4784	Polyp of Vocal Cords or Larynx
4785	Other Diseases of Vocal Cords
47870	Unspecified Diseases of Larynx
47879	Other Diseases of Larynx
4788	Upper Respiratory Tract Hypersensitivity Reaction., site unspecified
4789	Other and Unspecified Diseases of Upper Respiratory Tract
490	Bronchitis, not specified as acute or chronic
49100-49110	Chronic Bronchitis
49120	Obstructive Chronic Bronchitis without mention of exacerbation
4918	Other Chronic Bronchitis
4919	Unspecified Chronic Bronchitis
4920	Emphyematous Bieb
4928	Other Emphysema
49300	Extrinsic Asthma, without mention of status asthmaticus
49310	Intrinsic Asthma without mention of status asthmaticus
49320	Chronic Obstructive Asthma without mention of status asthmaticus
49390	Unspecified Asthma without mention of status asthmaticus
4940	Bronchiestasis without acute exacerbation
49500-50500	Extrinsic Allergic Alveolitis
5064	Chronic Respiratory Conditions due to fumes and vapors
5069	Unspecified Respiratory Conditions due to fumes and vapors
5081	Chronic and Other Pulmonary Manifestations due to radiation
5088	Respiratory Conditions due to Other Specified External Agents
5089	Respiratory Conditions due to Unspecified External Agents
514	Pulmonary Congestion and Hypostasis
515	Post-inflammatory Pulmonary Fibrosis
51600-51690	Other Alveolar and Parietoalveolar Pneumonopathy
51710-51780	Lung Involvement in conditions classified elsewhere
51810-51830	Intestitial or Compensatory Emphysema; Pulmonary Eosinophilia
5186	Allergic Bronchopulmonary Aspergillosis
51883-51889	Acute and Chronic Respiratory Failure; Other Diseases of Lungs not elsewhere classified
51910-51990	Other Diseases of Respiratory System
5200-5219	Disorders of Tooth Development and Eruption; Diseases of Hard Tissue of Teeth
52100-52109	Dental Carries
52510	Acquired Absence of Teeth
52512	Loss of Teeth Due to Peridontal Disease
52513	Loss of Teeth Due to Carries
52519	Other Loss of Teeth
53012	Acute Esophagitis
5220-5229	Diseases of Pulp and Periapical Tissues
5230-5239	Gingival and Periodontal Diseases
52400-52450	Major Anomalies of Jaw Size; Anomalies of Relationship of Jaw to Cranial Base
52460-52490	Temporomandibulat Joint Disorders; Dental Alveolar Anomalies
52500	Exfoliation of Teeth Due to Systemic Causes

52520-52590	Other Diseases and Conditions of the Teeth and Supporting Structures
52600-52690	Diseases of Jaws
52700-52790	Diseases of the Salivary Glands
52800-52820	Diseases of the Oral Soft Tissues, excluding Lesions Specific for Gingiva and Tongue;
52840-52890	Diseases of the Oral Soft Tissues, excluding Lesions Specific for Gingiva and Tongue;
52900-52990	Diseases and Other Conditions of the Tongue
53010-53019	Diseases of the Esophagus
53050-53060	Dyskinesia of Esophagus; Diverticulum of Esophagus, acquired
53081	Esophageal Reflux
53083	Esophageal Leukoplakia
53089	Other Disorder of Esophagus
5309	Unspecified Disorder of Esophagus
53170	Gastric Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53190	Gastric Ulcer, Unspecified as acute or chronic, without mention obstruction
53270	Duodenal Ulcer, Chronic, without mention of hemorrhage or perforation
53290	Duodenal Ulcer, Unspecified as acute or chronic, without mention of obstruction
53370	Peptic Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53390	Peptic Ulcer, Unspecified as acute or chronic, without mention of hemorrhage, perforation or obstruction
53470	Gastrojejunal Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53490	Gastrojejunal Ulcer, Unspecified as acute or chronic, without mention of hemorrhage, perforation or obstruction
53500	Acute Gastritis without mention of hemorrhage
53510	Atrophic Gastritis without mention of hemorrhage
53520	Gastric Mucosal Hypertrophy without mention of hemorrhage
53530	Alcoholic Gastritis without mention of hemorrhage
53540	Other Specified Gastritis without mention of hemorrhage
53550	Unspecified Gastritis and Gastroduodenitis without mention of hemorrhage
53560	Duodenitis without mention of hemorrhage
53600-53620	Achlorhydria; Acute Dilation of Stomach; Persistent Vomiting
53710-53720	Gastric Diverticulum; Chronic Duodental Ileus
53750-53760	Gastroptosis; Hourglass Stricture or Stenosis of Stomach
53781-53782	Pylorospasm; Anglodysplasia of Stomach and Duodenum without mention of hemorrhage
53789-53790	Other or Unspecified Disorder of Stomach and Duodenum
54300-54390	Other Diseases of Appendix
55090-55093	Inguinal Hernia, without mention of obstruction or gangrene
55500-55690	Regional Enteritis; Ulcerative Colitis
5589	Other and Unspecified Noninfectious Gastroenteritis and Colitis
56200-56201	Diverticulosis or Diverticulitis of Small Bowel without mention of hemorrhage
56210-56211	Diverticulosis or Diverticulitis of Colon without mention of hemorrhage
56400-56510	Functional Digestive Disorders and Other Specified Functional

	Disorders of Intestine, Anal Fissure or Fistula
56800-56880	Peritoneal Adhesions and Other Specified Disorders of Peritoneum
56882-56889	Peritoneal Effusion (chronic); Other and Unspecified Disorder of Peritoneum
5689	Unspecified Disorder of Peritoneum
56900-56920	Anal and Rectal Polyp; Stenosis of Rectum and Anus; Rectal Prolapse
56941-56949	Ulcer of Anus and Rectum; Anal or Rectal Pain; Other
56989-56990	Other and Unspecified Disorder of Intestine
5710	Alcoholic Fatty Liver
57120-57190	Chronic Liver Disease and Cirrhosis
57230-57280	Sequelae of Chronic Liver Disease
57300-57330	Other Disorders of Liver
57380-57390	Other Specified and Unspecified Disorders of Liver
5759	Unspecified Disorder of Gallbladder
5760	Postcholecystectomy Syndrome
57640-57690	Fistula of Bile Duct; Spasm of Sphincter of Oddi; Other Specified and Unspecified Diseases of Biliary Tract
57710-57790	Diseases of Pancreas
57900-57990	Intestinal Malabsorption
58100-58290	Nephrotic Syndrome; Other Specified Pathological Lesion in Kidney; Chronic Glomerulonephritis
58500-59001	Chronic Renal Failure; Disorders Resulting in Impaired Renal Function; Small Kidney of Unknown Cause; Chronic Pyelonephritis
5909	Infection of Kidney, Unspecified
591	Hydronephrosis
59300-59373	Other Disorders of Kidney and Ureter; Vesticoureteral Reflux
59389-59390	Other and Unspecified Disorders of Kidney and Ureter
59510-59590	Chronic and Other Interstitial Cystitis; Trigonitis; Cystitis in Diseases classified elsewhere; Other Specified Types of Cystitis
59600-59640	Other Disorders of Bladder
59651-59659	Other Functional Disorders of Bladder
59680-59690	Other and Unspecified Disorders of Bladder
59780-59789	Other Urethritis
59800-59890	Urethral Stricture due to infection
5990	Urinary Tract Infection, site not specified
59920-59940	Urethral Diverticulum, Caruncle; Urethral False Passage
59981-59990	Other Specified Disorders of Urethra and Urinary Tract
6000-60090	Hyperplasia of Prostate
6011	Chronic Prostatitis
6020	Calculus of Prostate
60220-60290	Atrophy of Prostate; Other Specified and Unspecified Disorders of Prostate
6023	Dysplasia of Prostate
6030	Encysted Hydrocele
6038	Other Specified types of Hydrocele
605	Redundant Prepuce and Phimosis
60600-60690	Infertility, male
6070	Leukoplakis of Penis
60784-60790	Impotence of Organic Origin; Other and Specified Disorders of Penis
60800-60810	Seminal Vesiculitis; Spermatocele

60830-60840	Atrophy of Testis; Other Inflammatory and Specified Disorders of Male Genital Organs
60881-60885	Other Specified Disorders of Male Genital Organs
60887	Retrograde Ejaculation
60889-60890	Other and Unspecified Disorder of Male Gential Organs
61000-61190	Benign Mammary Dyplasias; Other Disorders of Breast
6141	Chronic Salpingitis and Oophoritis
6142	Salpingitis and Oophoritis not specified as acute, subacute or chronic
6144	Chronic or Unspecified Parametritis and Pelvic Cellulitis
61460-61490	Pelvic Peritoneal Adhesions, female; Other Chronic Pelvic Peritonitis, female; Other Specified or Unspecified Inflammatory Diseases of Female Pelvic Organs and Tissues
61510-61590	Chronic and Unspecified Inflammatory Diseases of Uterus
61610-61620	Vaginitis and Vulvovaginitis; Cyst of Bartholin's Gland
61650-61651	Ulceration of Vulva
61680-61690	Other Specified and Unspecified Inflammatory Diseases of Cervix, Vagina, and Vulva
61700-61790	Endometriosis
61800-61890	Genital Prolapse
61900-61990	Fistulas involving Female Genital Tract
62000-62040	Noninflammatory Disorders Ovary, Fallopian Tube, and Broad Ligament
62080-62090	Other and Unspecified Noninflammatory Disorders of Ovary, Fallopian Tube, and Broad Ligament
62100-62350	Disorders of Uterus, not elsewhere classified; Noninflammatory Disorders of Cervix, Vagina
62370-62390	Polyp of Vagina; Other Specified and Unspecified Noninflammatory Disorders of Vagina
62400-62440	Noninflammatory Disorders of Vulva and Perineum
62460-62490	Polyp of Labia or Vulva; Other Specified or Unspecified Noninflammatory Disorders of Vulva and Perineum
62500-62590	Pain and Other Symptoms associated with Female Genital Organs
62600-62690	Disorders of Menstruation and Other Abnormal Bleeding from Female Genital Tract
62700-62790	Menopausal and Post Menopausal Disorders
62800-62890	Infertility, female
62900-62990	Other Disorders of Female Genital Organs
63100-63200	Missed Abortion; Other Abnormal Product of Conception
63790-63792	Unspecified Abortion without mention of complication
63890-63892	Failed Attempted Abortion without mention of complication
64300-64303	Mild Hyperemesis Gravidarum
64320-64393	Late, Other, Unspecified Vomiting of Pregnancy or Complicating Pregnancy
64510-64523	Late Pregnancy
64600-64603	Papyraceous Fetus
64610-64614	Edema or Excessive Weight Gain in Pregnancy without mention of hypertension
64620-64624	Unspecified Renal Disease in Pregnancy without mention of hypertension
64630-64633	Habitual Aborter
64640-64644	Peripheral Neuritis in Pregnancy
64650-64654	Asymptomatic Bacteriuria in Pregnancy
64660-64664	Infections of Genitourinary Tract in Pregnancy

64670-64673	Liver Disorders in Pregnancy
64680-64684	Other Specified Complications of Pregnancy
64690-64693	Unspecified Complications of Pregnancy
64790-64794	Unspecified Infection or Infestation affecting Conditions in the Mother
64890-64894	Other Current Conditions in the Mother
65500-65623	Known or Suspected Fetal Abnormality affecting management of mother
65650-65653	Poor Fetal Growth
65660-65663	Excessive Fetal Growth
65670-65673	Other Placental Conditions
65680-65683	Other Specified Fetal and Placental Problems
65690-65693	Unspecified Fetal and Placental Problems
65700-65730	Polyhydramnios
65800-65803	Oligohydramnios
65880-65883	Other Problems Associated with Amniotic Cavity and Membranes
65890-65893	Unspecified Problems Associated with Amniotic Cavity and Membranes
65900-65903	Failed Mechanical Induction
65910-65913	Failed Mechanical or Unspecified Induction
65940-65943	Grand Multiparity
65950-65953	Elderly Primigravida
65960-65963	Elderly Multigravida
65980-65983	Other Specified Indications for Care or Intervention Related To Labor and Delivery
65990-65993	Unspecified Indications for Care or Intervention Related To Labor and Delivery
66580	Other Specified Obstetrical Trauma
66590	Unspecified Obstetrical Trauma
67500	Infections of Nipple
67600-67604	Retracted Nipple
67610-67614	Cracked Nipple
67630-67634	Other and Unspecified Disorder of Breast
67640-67644	Failure of Lactation, Postpartum Condition or Complication
67650-67654	Suppressed Lactation
67660-67664	Galactorrhea
67680-67684	Other Disorders of Lactation
67690-67694	Unspecified Disorders of Lactation
677	Late Effect of Complication of Pregnancy, Childbirth and the Puerperium
68000-68090	Carbuncle and Furuncle
68100-68102	Cellulitis and Abscess of Finger
68110-68111	Cellulitis and Abscess of Toe
6819	Cellulitis and Abscess of Unspecified Digit
68200-68290	Other Cellulitis and Abscess
683	Acute Lymphadenitis
684	Impetigo
68500-68510	Pilonidal Cyst, with or without mention of Abscess
68600-68609	Pyoderma
6861	Pyogenic Granuloma
68680-68690	Other and Unspecified Local Infections of Skin and Subcutaneous Tissue
69010-69012	Seborrheic Dermatits

69018	Other Seborrheic Dermatits
69080	Other Erythematosquamous Dermatosis
6910	Diaper or Napkin Rash
6918	Atopic Dermatitis and related conditions
69201-69260	Contact Dermatitis and Other Eczema
69270-69279	Contact Dermatitis due to solar radiation
69280-69290	Contact Dermatitis due to other specified agent
69300-69390	Dermatitis due to substances taken internally
69400-69450	Bullous Dermatoses
69460-69490	Benign Mucous Membrane Pemphogoid
69500-69590	Erythematous Conditions
69600-69680	Psorasis and Similar Disorders
69700-69790	Lichen
69800-69890	Pruritus and Other Related Conditions; Corns and Callosities
700	Corns and Callosities
70100-70190	Other Hypertropic and Atropic Conditions of Skin
70200-70280	Other Dermatoses; Seborrheic Keratosis
70300-70390	Diseases of Nail
70400-70490	Alopecia
70500-70590	Disorders of Sweat Glands
70600-70690	Diseases of Sebaceous Glands
7070	Decubitus Ulcer
70710-70790	Ulcer of Lower Limbs, except decubitus
70800-70890	Uticaria
70900-70909	Dyschromia
70910-70990	Other Disorders of Skin and Subcutaneous Tissue
71000-71090	Diffuse Disease of Connective Tissue
71100-71109	Pyogenic Arthritis
71110-71119	Arthropathy Associated with Reiter's Disease and Nonspecific Urethritis
71120-71129	Arthropathy in Bechet's Syndrome
71130-71139	Postdysenteric Arthropathy
71140-71149	Arthropathy Associated with other Bacterial Diseases
71150-71159	Arthropathy Associated with other Viral Diseases
71160-71169	Arthropathy Associated with Mycoses
71170-71179	Arthropathy Associated with Helminthiasis
71180-71189	Arthropathy Associated with Other Infections and Parasitic Diseases
71190-71199	Unspecified Infective Arthritis
71210-71219	Chondrocalcinosis Due to Dicalcium Phoshate Crystals
71220-71229	Chondrocalcinosis Due to Pyrophosphate Crystals
71230-71239	Chondrocalcinosis, Unspecified
71280-71289	Other Specified Crystal Arthropathies
71290-71299	Unspecified Crystal Arthropathy
71300-71380	Arthropathy Associated with other disorders classified elsewhere
71400-71420	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies
71430-71440	Juvenile Chronic Polysrthritis
71481-71490	Other Specified Inflammatory Polyarthropathies
71500-71598	Osteoarthrosis and Allied Disorders
71600-71609	Kaschin-Beck Disease
71620-71629	Allergic Arthritis
71630-71639	Climateric Arthritis
71640-71649	Transient Arthropathy
71650-71659	Unspecified Polyarthropathy or Polyarthritis

71660-71668	Unspecified Monoarthritis
71680-71689	Other Specified Arthropathy
71690-71699	Arthropathy, unspecified
71781-71790	Other and Unspecified Internal Derangement of Knee
71800-71819	Other Derangement of Joint; Articular Cartilage Disorder; Loose body in Joint
71830-71859	Recurrent Dislocation of Joint; Contracture of Joint; Anklosis of Joint
71870-71899	Other Joint Derangement, not elsewhere classified or unspecified
71900-71909	Effusion of Joint
71920-71949	Villonodular Synovitis; Palindromic Rheumatism; Pain in Joint
71950-71999	Stiffness in Joint, not elsewhere classified; Other Symptoms referable to Joint; Difficulty in Walking; Other Specified and Unspecified Disorders of Joint
72081	Inflammatory Spondylopathies in disease classified elsewhere
72089-72090	Other and Unspecified Inflammatory Spondylopathy
72100-72130	Spondylosis and Allied Disorders
72141-72191	Thoracic or Lumbar or Unspecified Site Spondylosis without Myelopathy
7220	Displacement of Cervical Intervertebral Disc with Myelopathy
72210-72220	Displacement of Thoraic or Lumbar Intervertebral Disc with Myelopathy
72230-72239	Schmorl's Nodes
72240-72260	Degeneration of Thoraic, Lumbar or Site Unspecified Intervertebral Disc
72270-72273	Intervertebral Disc Disorder with Myelopathy
72280-72283	Postlaminectomy Syndrome
72290-72293	Other and Unspecified Disc Disorder
72300-72390	Other Disorders of Cervical Region
72400-72460	Spinal Stenosis, other than cervical in cervical region
72470-72479	Disorders of Coccyx
72480-72490	Other and Unspecified Symptoms or Disorders referable to Back
725	Polymyalgia Rheumatica
72601-72619	Peripheral Enthesopathies and Allied Syndromes
7262	Other Affections of Shoulder Region, not elsewhere classified
72630-72633	Enthesopathy of Elbow; Medial and Lateral Epicondyitis; Olecranon Bursitis
72639	Other Enthesopathy of Elbow Region
7264	Enthesopathy of Wrist, Carpus
7265	Enthesopathy of Hip Region
72660-72669	Enthesopathy of Knee
72670-72673	Enthesopathy of Ankle and Tarsus; Achilles Bursitis or Tendinitis; Tibialis Tendinitis; Calcaneal Spur
72679-72680	Other Enthesopathy of Ankle and Tarsus; Other Peripheral Enthesopathies
72690	Enthesopathy of unspecified site
72691	Exostosis of unspecified site
72700-72709	Synovitis and Tenosynovitis
7271	Bunion
7272	Specific Bursitides Often of Occupational Origin
7273	Other Bursitis
72740-72749	Ganglion and Cyst of Synovium, Tendon, and Bursa
72781-72790	Other Disorders of Synovium, Tendon, and Bursa

72810	Muscular Calcification and Ossification
72819	Other Muscular Calcification and Ossification
72820-72860	Muscular Wasting and Disuse Atrophy, not elsewhere classified; Other Specific Muscle Disorders; Laxity of Ligament; Hypermobility Syndrome; Contracture of Palmar Fascia
72871-72879	Other Fibromatoses
72882-72890	Other and Unspecified Disorders of Muscle, Ligament, and Fascia
72900-72920	Other Disorders of Soft Tissues
72930-72939	Panniculitis, Unspecified Site, Hypertrophy of Fat Pad, Knee; Other Site
7294	Fasciitis, Unspecified
7295	Pain in Limb
7296	Residual Foreign Body in Soft Tissue
72981-72990	Other Musculoskeletal Symptoms Referable to Limbs; Other and Unspecified Disorders of Soft Tissue
73010-73019	Chronic Osteomyelitis
73020-73029	Unspecifed Osteomyelitis
73030-73039	Periostitis without mention of Osteomyelitis
73070-73079	Osteopathy Resulting from Poliomyelitis
73080-73089	Other Infections Involving Bone in diseases classified elsewhere
73090-73099	Unspecified Infection of Bone
73100-73180	Osteitis Deformans and Osteopathies Associated with Other Disorders classified elsewhere
73200-73290	Osteochondropathies
73300-73309	Osteoprosis
73320-73329	Cyst of Bone
7333	Hyperostosis of Skull
73340-73349	Aseptic Necrosis of Bone
7335	Osteitis Condensans
7336	Tietze's Disease
7337	Algoneurodystrophy
73381-73382	Malunion and Nonunion of Fracture
73390-73392	Disorder of Bone and Caritlage, Unspecified; Arrest of Bone Development or Growth
73399	Other Disorders of Bone and Cartilage
734	Flat Foot
73500-73590	Acquired Deformities of Toe
73600-73609	Acquired Deformities of Forearm, excluding fingers
7361	Mallet Finger
73620-73629	Other Acquired Deformities of Finger
73630-73639	Acquired Deformities of Hip
73641-73660	Genu Vaigum or Varum (acquired)
73670-73679	Other Acquired Deformities of Ankle and Foot
73681-73689	Acquired Deformities of Other Parts of Limb
7369	Acquired Deformity of Limb, site unspecified
7370	Adolescent Postural Kyphosis
73710-73719	Kyphosis (acquired)
73720-73729	Lordosis (acquired)
73730-73739	Kyphoscoliosis and Scoliosis
73740-73790	Curature of Spine Associated with other conditions
7380	Other Acquired Deformity of Nose
73810-73812	Other Acquired Deformity of Head; Zygomatic Hyperplasia or Hypoplasia

73819	Other Specified Deformity
7382	Acquired Deformity of Neck,
7383	Acquired Deformity of Chest and Rib
7384	Acquired Spondylolisthesis
7385	Other Acquired Deformity of Back or Spine
7386	Acquired Deformity of Pelvis
7387	Cauliflower Ear
7388	Acquired Deformity of Other Specified Site
7389	Other Acquired Deformity of Unspecified Sites
73900-73990	Nonallopathic Lesions, not elsewhere classified
74000-74020	Anencephalus and Similar Anomalies
74100-74193	Spina Bifida with or without mention of Hydrocephalus
74200-74240	Other Congenital Anomalies of Nervous System
74251-74259	Other Specified Anomalies of Spinal Cord
74280-74290	Other Specified and Unspecified Anomalies of Brain, Spinal Cord or Nervous System
74300-74306	Anophthalmos
74310-74312	Microphthalmos
74320-74322	Buphthalmos
74330-74339	Congenital Cataract and Lens Anomalies
74341-74349	Coloboma and Other Anomalies of Anterior Segment
74351-74359	Congenital Anomalies of Posterior Segment
74361-74369	Congenital Anomalies of Eyelids, Lacrimal System, and Orbit
74380-74390	Other Specified and Unspecified Anomaly of Eye
74400-74409	Anomalies of Ear causing Impairment of Hearing
7441	Accessary Auricle
74421-74429	Other Specified Anomalies of Ear
7443	Unspecified Anomalies of Ear
74441-74449	Branchial Cleft Cyst or Fistula; Perauricular Sinus
7445	Webbing of Neck
74481-74489	Other Specified Anomalies of Face and Neck
7449	Unspecified Anomalies of Face and Neck
7450	Bulbus Cordis Anomalies and Anomalies of Cardiac Septal Closure
74512-74519	Correction Transposition of Great Vessels; Other
74560-74569	Endocardial Cushion Defects
7457	Cor Biloculare
74580-74590	Other and Unspecified Defect of Septal Closure
74720-74729	Other Anomalies of Aorta
7473	Anomalies of Pulmonary Artery
74740-74749	Anomalies of Great Viens
7475	Absence or Hypoplasis of Umbilical Artery
74760-74769	Other Anomalies of Peripheral Vascular System
74781-74789	Other Specified Anomalies of Circulatory System
7479	Unspecified Anomaly of Circulatory System
74800-74850	Unspecified Anomalies of Respiratory System
74860-74890	Other Anomalies of Lung
74900-74904	Cleft Palate
74910-74914	Cleft Lip
74920-74925	Cleft Palate with Cleft Lip
75000-75019	Other Congenital Anomalies of Upper Alimentary Tract
75021-75029	Other Specified Anomalies of Mouth and Pharynx
7503	Tracheoesophageal Fistula, Esophageal Atresia and Stenosis
7504	Other Specified Anomalies of Esophagus

7505	Congenital Hypertonic Pyloric Stenosis
7506	Congenital Hiatus Hernia
7507	Other Specified Anomalies of Stomach
7508	Other Specified Anomalies of Upper Alimentary Tract
7509	Unspecified Anomaly of Upper Alimentary Tract
75100-75150	Other Congenital Anomalies of Digestive System
75160	Anomalies of Gallbladder, Bile Ducts, and Liver
75162-75169	Congenital Cystic Disease of Liver; Other Anomalies of Gallbladder, Bile Ducts and Liver
7517	Anomalies of Pancreas
7518	Other Specified Anomaly of Digestive System
7519	Unspecified Anomalies of Digestive System
7520	Anomalies of Ovaries
75210-75219	Anomalies of Fallopian Tubes and Broad Ligament
7522	Doubling of Uterus
7523	Other Anomalies of Uterus
75240-75242	Unspecified Anomaly or Embroyonic cycst of Cervix, Vagina, and External Female Genitalia; Imperforate Hymen
75249	Other Anomalies of Cervix, Vagina, and External Female Genitalia
75251-75252	Undescended and Retractable Testicle
75261-75269	Hypospadias and Epispadias and Other Penile Anomalies
7527	Indeterminate Sex and Pseudohermaphroditism
7528	Other Specified Anomalies of Genital Organs
7529	Unspecified Anomalies of Genital Organs
7530	Renal Agenesis and Dysgenesis
75310-75319	Cystic Kidney Disease
75320-75329	Obstructive Defects of Renal Pelvis and Ureter
7533	Other Specified Anomalies of Kidney
7534	Other Specified Anomalies of Ureter
7535	Exstropy of Urinary Bladder
7536	Atresia and Stenosis of Urethra and Bladder Neck
7537	Anomalies of Urachus
7538	Other Specified Anomalies of Bladder and Urethra
7539	Unspecified Anomaly of Urinary System
75400-75420	Certain Congenital Musculoskeletal Deformities
75430-75435	Congenital Dislocation of Hip
75440-75444	Congenital Genu Recurvatum and Bowing of Bones of Leg
75450-75459	Varus Deformities of Feet
75460-75469	Valgas Deformities of Feet
75470-75479	Other Deformities of Feet
75481-75489	Other Specified Nonteratogenic Anomalies
75500-75502	Poldactyly
75510-75514	Syndactyly
75520-75529	Reduction Deformities of Upper Limb
75530-75539	Reduction Deformities of Lower Limb
7554	Reduction Deformities, Unspecified Limb
75550-75559	Other Anomalies of Upper Limb, including Shoulder Girdle
75560-75569	Other Anomalies of Lower Limb, including Pelvic Girdle
7558	Other Specified Anomalies of Unspecified Limb
7559	Unspecified Anomaly of Unspecified Limb
7560	Anomalies of Skull and Face Bones
75610-75640	Anomalies of Spine
75650-75659	Osteodystrophies

7566	Anomalies of Diaphragm
75670-75679	Anomalies of Abdominal Wall
75681-75689	Other Specified Anomalies of Muscle, Tendon, Fascia, and Connective Tissues
7569	Other and Unspecified Anomalies of Musculoskeletal System
75700-75720	Congenital Anomalies of the Integument
75731	Congenital Ectodermal Dysplasia
75732	Vascular Hamartomas
75733	Congenital Pigmentary Anomalies of Skin
75739	Other Congenital Anomalies of Integument
7574	Specified Anomalies of Hair
7575	Specified Anomalies of Nails
7576	Specified Anomalies of Breast
7578	Other Specified Anomalies of Integument
7579	Unspecified Anomalies of the Integument
75800-75870	Chromosomal Anomalies
75881-75889	Other Conditions due to Chromosome Anomalies
7589	Conditions Due to Anomaly of Unspecified Chromosome
75900-75970	Other and Unspecified Congenital Anomalies
75981-75989	Other Specified Anomalies
75999	Congenital Anomaly, unspecified
7793	Feeding Problems in Newborn
7796	Termination of Pregnancy (fetus)
77980-77990	Other Specified and Unspecified Conditions originating in the perinatal period
7801	Hallucinations
7804	Dizziness and Giddiness
78050-78059	Sleep Disturbances
7806	Fever
78071	Malaise and Fatigue
78079	Other Malaise and Fatigue
7808	Hyperhidrosis
78090-78099	Other General Symptoms
7818	Neurologic Neglect Syndrome
78191-78199	Other Symptoms Involving Nervous and Musculoskeletal Systems
78200-78240	Symptoms Involving Skin and Integumentary Tissue
78261-78262	Pallor and Flushing
7827	Spontaneous Ecchynoses
7828	Changes in Skin Texture
7829	Other Symptoms Involving Skin and Integumentary Tissue
78300-78390	Symptoms concerning Nutrition, Metabolism and Development
78400-78420	Symptoms Involving Head and Neck
78440-78449	Voice Disturbance
7845	Other Speech Disturbance
78460-78469	Other Symbolic Dysfunction
7847	Epistaxis
7849	Other Symptoms Involving Head and Neck
7852	Undiagnosed Cardiac Murmurs
7853	Other Abnormal Heart Sounds
7856	Enlargement of Lymph Nodes
7859	Other Symptoms involving Cardiovascular System
78600-78602	Dyspnea and Respiratory Abnormalities
78605	Shortness of Breath

78606	Tachypnea
78607	Wheezing
78609	Other Symptoms involving Respiratory System
7862	Cough
7864	Abnormal Sputum
78650	Chest Pain, Unspecified
78652	Painful Respiration
78659	Other Symptoms of Chest Pain
7866	Swelling, Mass, or Lump in Chest
7867	Abnormal Chest Sounds
7868	Hiccough
7869	Other Symptoms involving Respiratory System and Chest
78701-78703	Symptoms involving Digestive System
7871	Heartburn
7872	Dyphagia
7873	Flatulence, Erutation, and Gas Pain
7874	Visible Peristalsis
7875	Abnormal Bowel Sounds
7876	Incontinence of Feces
7877	Abnormal Feces
78791-78799	Other Symptoms Involving Digestive System
7881	Dysuria
78820	Retention of Urine, Unspecified
78821	Incomplete Bladder Emptying
78829	Other Specified Retention of Urine
78830-78839	Incontinence of Urine
78841-78843	Frequency of Urination and Polyuria
7885	Oliguria and Anuria
78861-78869	Other Abnormality of Urination
7888	Extravasation of Urine
7889	Other Symptoms of Urine
78900-78909	Other Symptoms Involving Abdomen and Pelvis
7891	Hepatomegaly
7892	Splenomegaly
78930-78939	Abdominal or Pelvic Swelling, Mass or Lump
78940-78949	Abdominal Rigidity
7895	Ascites
78960-78969	Abdominal Tenderness
7899	Other Symptoms Involving Abdomen and Pelvis
79001-79060	Nonspecific Findings on Examination of Blood
7908	Viremia, unspecified
79091-79099	Other Nonspecific on Examination of Blood
79100-79190	Nonspecific on Examination of Urine
7924	Abnormal Findings on Examination of Saliva
7925	Cloudy (hemodialysis) (peritoneal) Dialysis Effluent
7929	Other Nonspecific Abnormal Findings in Body Substances
79300-79390	Nonspecific Abnormal Findings on Radiological and Other Exam of Body Structure
79400-79409	Nonspecific Abnormal Results of Function Studies
79410-79419	Peripheral Nervous System and Special Senses
7942	Pulmonary
79430-79439	Cardiovascular
7944	Kidney
7945	Thyroid

7946	Other Endocrine Function Study
7947	Basal Metabolism
7948	Liver
7949	Other
79500-79560	Nonspecific Abnormal Histological and Immunological Findings
79571	Nonspecific Serology Evidence of Human Immunodeficiency Virus
79579	Other and Unspecified Nonspecific Immunological Findings
79600-79690	Other Nonspecific Abnormal Findings
797	Senility without Mention of Psychosis
7992	Nervousness
7993	Debility, unspecified
7994	Cachexia
7998	Other Ill-Defined Conditions
7999	Other Unknown or Unspecified Cause
84600-84899	Sprains and Strains
90500-90590	Late Effects of Musculoskeletal and Connective Tissue Injuries
90600-90690	Late Effects of Injuries to Skin and Subcutaneous Tissues
90700-90790	Superficial Insect Bite, Nonvenomous, without mention of Infection on Face, Neck, or Scalp except Eye
90800-90890	Late Effects of Other and Unspecified Injuries
90900-90990	Late Effects of Other and Unspecified External Causes
91000-91090	Superficial Injury to Face, Neck or Scalp except Eye
91100-91190	Superficial Injury of Trunk
91200-91290	Superficial Injury of Shoulder and Upper Arm
91300-91390	Superficial Injury of Elbow, Forearm, and Wrist
91400-91490	Superficial Injury of Hand(s) except Finger(s) alone
91500-91590	Superficial Injury of Finger(s)
91600-91690	Superficial Injury of Hip, Thigh, Leg, and Ankle
91700-91790	Superficial Injury of Foot and Toe(s)
91900-91990	Superficial Injury of Other, Multiple, and Unspecified Sites
92200-92220	Contusion of Trunk
92230-92290	Contusion of Back
92300-92309	Contusion of Shoulder and Upper Arm
92310-92311	Contusion of Elbow and Forearm
92320-92321	Contusion of Wrist and Hand(s), Except Finger(s) alone
9233	Contusion of Finger
92380-92390	Contusion of Multiple Sites and Unspecified Part of Upper Limb
92400-92401	Contusion of Hip and Thigh
92410-92411	Contusion of Knee and Lower Leg
92420-92421	Contusion of Ankle and Foot, excluding Toe(s)
9243	Contusion of Toe
9244	Contusion of Multiple Sites of Lower Limb
9245	Contusion of Unspecified Part of Lower Limb
9248	Contusion of Multiple Sites, not elsewhere classified
9249	Contusion of Unspecified Site
9952	Unspecified Adverse Effect of Drug, Medicinal and Biological Substance
9990-9999	Complications or Medical Care, not elsewhere classified
V0100-V4589	All in this range
V4690-V6120	All in this range
V6129-V7130	All in this range
V717	All in this range
V7189-V8299	All in this range

V8301-**V8389**	All in this range
E9600	Unarmed Fight or Brawl
E969	Late Effects of Injury purposely Inflicted by Other Person
E999	Late Effects of Injury due to War Operations

MANDATORY OUTPATIENT SURGICAL LIST
Revised 03/01/00

INTEGUMENTARY SYSTEM

Incision and Drainage

ICD-9-CM Codes	CPT Codes	Description
86.03	10081	Incision and drainage of pilonidal cyst; complicated
86.05	10121	Incision and removal of foreign body, subcutaneous tissues; complicated
86.04	10140	Incision and drainage of hematoma, seroma, or fluid collection
86.01	10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
86.22	11040	Debridement; skin, partial thickness

Excision-Benign Lesion(s)

85.21 86.3	11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms, or legs; lesion diameter 0.5 cm or less
85.21 86.3	11401	lesion diameter 0.6 to 1.0 cm
85.21 86.3	11402	lesion diameter 1.1 to 2.0 cm
85.21 86.3	11403	lesion diameter 2.1 to 3.0 cm
85.21 86.3	11404	lesion diameter 3.1 to 4.0 cm
85.21 86.3	11406	lesion diameter over 4.0 cm
86.3	11420	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
86.3	11422	lesion diameter 1.1 to 2.0 cm

86.3	11423	lesion diameter 2.1 to 3.0 cm
86.3	11424	lesion diameter 3.1 to 4.0 cm
86.3	11426	lesion diameter over 4.0 cm
08.20 08.23 21.30 21.32 86.3	11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion 0.5 cm or less
08.20 08.23 21.30 21.32 86.3	11441	lesion diameter 0.6 to 1.0 cm
08.20 08.23 21.30 21.32 86.3	11442	lesion diameter 1.1 to 2.0 cm
08.20 08.23 21.30 21.32 86.3	11443	lesion diameter 2.1 to 3.0 cm
08.20 08.23 21.30 21.32 86.3	11444	lesion diameter 3.1 to 4.0 cm
08.20 08.23 21.30 21.32 86.3	11446	lesion diameter over 4.0 cm

Excision-Malignant Lesion(s)

85.21 86.3	11600	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 1.5 cm or less
85.21 86.3	11601	lesion diameter 0.6 to 1.0 cm
85.21 86.3	11602	lesion diameter 1.1 to 2.0 cm
85.21	11603	lesion diameter 2.1 to 3.0 cm

86.3		
85.21 86.3	11604	lesion diameter 3.1 to 4.0 cm
85.21 86.3	11606	lesion diameter over 4.0 cm
85.21 86.3	11620	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
85.21 86.3	11621	lesion diameter 0.6 to 1.0 cm
86.3	11622	lesion diameter 1.1 to 2.0 cm
86.3	11623	lesion diameter 2.1 to 3.0 cm
86.3	11624	lesion diameter 3.1 to 4.0 cm
86.3	11626	lesion diameter over 4.0 cm
21.30 21.32 86.3	11640	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less
08.20 08.24 21.30 21.32 86.3	11641	lesion diameter 0.6 to 1.0 cm
08.20 08.24 21.30 21.32	11642	lesion diameter 1.1 to 2.0 cm
08.20 08.24 21.30 21.32 86.3	11643	lesion diameter 2.1 to 3.0 cm
08.20 08.24 21.30 21.32 86.3	11644	lesion diameter 3.1 to 4.0 cm

08.20 08.24 21.30 21.32 86.3	11646	lesion diameter over 4.0 cm

Nails

86.23	11730	Avulsion of nail plate, partial or complete, simple; single
86.23	11731	second nail plate
86.23	11732	each additional nail plate
86.04	11740	Evacuation of subungual hematoma
86.23	11750	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;
84.00 86.23	11752	with amputation of tuft of distal phalanx
86.11	11755	Biopsy of nail unit, any method (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail fold) (separate procedure)
86.89	11760	Repair of nail bed
86.86	11762	Reconstruction of nail bed with graft
86.23	11765	Wedge resection of skin of nail fold (e.g., for ingrown toenail)
86.21	11770	Excision of pilonidal cyst or sinus; simple

Introduction

86.02	11950	Subcutaneous injection of "filling" material (e.g. collagen); 1 cc or less
86.02	11951	1.1 to 5.0 cc

Repair-Simple

86.59	12020	Treatment of superficial wound dehiscence; simple closure

Free Skin Grafts

86.60	15050	Pinch graft, single of multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter

Other Procedures

08.70 08.86	15820	Blepharoplasty, lower eyelid;
08.70 08.87	15822	Blepharoplasty. upper eyelid;
97.38 97.43 97.49 97.59 97.69 97.83 97.84 97.89	15850	Removal of sutures under anesthesia (other than local), same surgeon
97.38 97.43 97.49 97.59 97.69 97.83 97.84 97.89	15851	Removal of sutures under anesthesia (other than local), other surgeon
93.57	15852	Dressing change (for other than burns) under anesthesia (other than local)

Burns, Local Treatment

93.57	16000	Initial treatment, first degree burn, when no more than local treatment is required
86.22 86.28 93.56 93.57	16010	Dressing and/or debridement, initial or subsequent; under anesthesia, small
86.22 86.28 93.56 93.57 93.57	16020	without anesthesia, office or hospital, small

86.22 86.28 93.56 93.57	16025	without anesthesia, medium (e.g., whole face or whole extremity)
86.22 86.28 93.56 93.57	16030	without anesthesia, large (e.g., more than one extremity)

Breast

Incision

85.91	19000	Puncture aspiration of cyst of breast;
85.91	19001	each additional cyst
85.0	19020	Mastotomy with exploration or drainage of abscess, deep
85.92 87.35	19030	Injection procedure only for mammary ductogram or galactogram

Excision

85.11	19100	Biopsy of breast; needle core
85.12	19101	incisional
85.0 85.20 85.25	19110	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct
85.20	19112	Excision of lactiferous duct fistula
85.20 85.21 85.24 85.25	19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions
85.21	19125	Excision of breast lesion identified by preoperative placement of radiological marker; single lesion
85.21	19126	each additional lesion separately identified by a radiological marker

85.32 85.34 85.36		19140	Mastectomy for gynecomastia

Introduction

85.19	19290	Preoperative placement of needle localization wire, breast;
85.19	19291	each additional lesion

Repair and/or Reconstruction

85.94	19328	Removal of intact mammary implant
85.94	19330	Removal of mammary implant material
99.99	19396	Preparation of moulage for custom breast implant

MUSCULOSKELETAL SYSTEM

Biopsy

83.21	20205	Biopsy, muscle, deep
77.40 77.41 77.42 77.43 77.44 77.46 77.47 77.48 77.49	20220	Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs)
77.40 77.41 77.42 77.43 77.44 77.46 77.47 77.48 76.11	20240	Biopsy, excisional; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)

Introduction or Removal

83.98 87.38 88.14	20501	Injection of sinus tract; diagnostic (sinogram)

83.01 83.02 98.27 98.28 98.29	20520	Removal of foreign body in muscle or tendon sheath; simple
83.01 83.02 98.27 98.28 98.29	20525	deep or complicated
81.91 81.92 82.92 82.94 82.95 83.92 93.96	20600	Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g.. fingers, toes)
76.96 81.91 81.91 81.92 83.94 93.96	20605	intermediate joint, bursa, or ganglion cyst (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)
81.91 81.92 83.94 83.96	20610	major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)
78.40 78.41 78.43 78.44 78.45 78.46 78.46 78.48 78.49	20615	Aspiration and injection for treatment of bone cyst
02.95	20665	Removal of tongs or halo applied by another physician
76.97 78.60-78.64 78.66-78.69 80.02 97.35 97.36	20670	Removal of implant; superficial, (e.g., buried wire, pin or rod)
93.44	20693	Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))
78.60-78.69	20694	Removal, under anesthesia, of external fixation system

Other Procedures

83.92	99.86	20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)

Head

Incision

80.19		21010	Arthrotomy, temporomandibular joint

Excision

76.31		21040	Excision of benign cyst or tumor of mandible; simple

Introduction or Removal

76.96	87.13	21116	Injection procedure for temporomandibular joint arthrography

Repair, Revision, and/or Reconstruction

08.59		21280	Medial canthopexy
08.59		21282	Lateral canthopexy

Fracture and/or Dislocation

21.99		21310	Closed treatment of nasal bone fracture without manipulation
21.71		21315	Closed treatment of nasal bone fracture without stabilization
21.71		21320	with stabilization
21.72		21325	Open treatment of nasal fracture; uncomplicated
21.71		21337	Closed treatment of nasal septal fracture, with or without stabilization
76.73	76.75	21440	Closed treatment of mandibular or maxillary alveolar ridge fracture
76.75		21450	Closed treatment of mandibular fracture; without manipulation

76.75		21451	with manipulation
76.75	78.19	21452	Percutaneous treatment of mandibular fracture, with external fixation
76.75		21453	Closed treatment of mandibular fracture with interdental fixation
76.93	76.95	21480	Closed treatment of temporomandibular dislocation; initial or subsequent
76.93	76.95	21485	complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent

Neck

Repair, Revision, and/or Reconstruction

83.19	21700	Division of scalenus anticus; without resection of cervical rib

Fracture and/or Dislocation

79.09	21800	Closed treatment of rib fracture, uncomplicated, each

Back and Flank

Excision

83.32	83.39	21930	Excision, tumor, soft tissue of back or flank

Spine (Vertebral Column)

Manipulation

84.89	22505	Manipulation of spine requiring anesthesia, any region

Abdomen

54.3	22900	Excision, abdominal wall tumor, subfascial (e.g., desmoid)

Shoulder

Incision

83.39	23000	Removal of subdeltoid (or intratendinous) calcareous deposits, open method
80.41 83.19	23020	Capsular contracture release (Sever type procedure)
83.02	23030	Incision and drainage, shoulder area; deep abscess or hematoma
80.11	23040	Arthrotomy, glenohumeral joint, for infection, with exploration, drainage or removal of foreign body
80.11 80.19	23044	Arthrotomy, acromioclavicular, sternoclavicular joint, for infection, with exploration, drainage or removal of foreign body

Excision

80.11 80.31	23100	Arthrotomy with biopsy, glenohumeral joint
80.31 80.91	23101	Arthrotomy with biopsy, or with excision of torn cartilage, acromioclavicular, sternoclavicular joint
80.11 80.71	23105	Arthrotomy with synovectomy; glenohumeral joint
80.19 80.71	23106	sternoclavicular joint
80.11	23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body

Introduction or Removal

81.92 88.32	23350	Injection procedure for shoulder arthrography

Fracture and/or Dislocation

93.54	23500	Closed treatment of clavicular fracture; without manipulation

79.09		23505	with manipulation
79.79		23520	Closed treatment of sternoclavicular dislocation; without manipulation
79.79		23525	with manipulation
93.59		23540	Closed treatment of acromioclavicular dislocation; without manipulation
79.79		23545	with manipulation
79.09 93.59	93.54	23570	Closed treatment of scapular fracture; without manipulation
79.01	93.54	23600	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation
79.01	79.11	23605	with manipulation, with or without skeletal traction
79.71		23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia
79.71		23655	requiring anesthesia

Humerus (Upper Arm) and Elbow

Incision

83.09	23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma
80.12	24000	Arthrotomy, elbow, for infection, with exploration, drainage or removal of foreign body
80.92	24006	Arthrotomy of the elbow, with capsular excision for capsular release

Excision

80.32	24100	Arthrotomy, elbow, with synovial biopsy only

80.32	80.92	24101	with joint exploration, with or without biopsy, with or without removal of loose or foreign body
80.72		24102	with synovectomy
83.5		24105	Excision, olecranon bursa
77.62		24110	Excision or curettage of bone cyst or benign tumor, humerus;
77.63		24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process

Introduction or Removal

78.63	78.69	24160	Implant removal; elbow joint
78.63	78.69	24164	radial head
81.92	88.32	24220	Injection procedure for elbow arthrography

Fracture and/or Dislocation

93.53		24500	Closed treatment of humeral shaft fracture; without manipulation
79.01		24505	with manipulation, with or without skeletal traction
93.54		24560	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation
79.01		24565	with manipulation
79.11		24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation
79.11	93.54	24576	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation
79.11		24577	with manipulation

79.11	24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation
79.72	24600	Treatment of closed elbow dislocation; without anesthesia
79.72	24605	requiring anesthesia
79.72	24640	Closed treatment of radial head subluxation in child, "nursemaid elbow", with manipulation
93.54	24650	Closed treatment of radial head or neck fracture; without manipulation
79.02	24655	with manipulation
93.54	24670	Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation
79.02	24675	with manipulation

Forearm and Wrist

Incision

83.01	25000	Tendon sheath incision; at radial styloid (e.g., for deQuervain's disease)
83.02 83.09	25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma
80.13	25040	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body

Excision

80.43	25085	Capsulotomy, wrist (e.g., for contracture)
80.13	25100	Arthrotomy, wrist joint; with biopsy
80.13 80.33	25101	with joint exploration, with or without biopsy, with or without removal of loose or foreign body

80.73		25105	with synovectomy
80.73		25107	Arthrotomy, distal radioulnar joint for repair of triangular cartilage complex
80.79		25110	Excision, lesion of tendon sheath, forearm and/or wrist
82.21		25111	Excision of ganglion, wrist (dorsal or volar); primary
82.21		25112	recurrent
83.39	83.5	25115	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors
83.31	83.5	25116	extensors, with or without transposition of dorsal retinaculum
80.83		25120	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
80.83		25130	Excision or curettage of bone cyst or benign tumor of carpal bones;
77.84	77.94	25210	Carpectomy; one bone
77.83		25230	Radial styloidectomy

Introduction or Removal

81.92	88.32	25246	Injection procedure for wrist arthrography
83.02 81.91	83.09 98.27	25248	Exploration with removal of deep foreign body, forearm or wrist

Fracture and/or Dislocation

93.53		25500	Closed treatment of radial shaft fracture; without manipulation
79.02	93.53	25505	with manipulation

93.53		25530	Closed treatment of ulnar shaft fracture; without manipulation
79.02	93.53	25535	with manipulation
93.53		25560	Closed treatment of radial and ulnar shaft fractures; without manipulation
79.02	93.53	25565	with manipulation
93.53		25622	Closed treatment of carpal scaphoid (navicular) fracture; without manipulation
79.03	93.53	25624	with manipulation
79.03		25630	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); without manipulation, each bone
79.03		25635	with manipulation, each bone
93.53		25650	Closed treatment of ulnar styloid fracture
79.73		25660	Closed treatment of radiocarpal or intercarpal dislocation, one or more bones; with manipulation
79.73		25675	Closed treatment of distal radioulnar dislocation with manipulation
79.03	79.73	25680	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation
79.73		25690	Closed treatment of lunate dislocation, with manipulation

Hand and Fingers

Incision

82.12	26040	Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous)
82.12	26045	open, partial

83.01	26055	Tendon sheath incision (e.g., trigger finger)
82.11	26060	Tenotomy, subcutaneous, single, each digit
80.14	26070	Arthrotomy, for infection, with exploration, drainage or removal of foreign body; carpometacarpal joint
80.14	26075	metacarpophalangeal joint
80.14	26080	interphalangeal joint, each

Excision

80.34	26100	Arthrotomy with synovial biopsy; carpometacarpal joint
80.34	26105	metacarpophalangeal joint
80.34	26110	interphalangeal joint, each
82.35	26121	Fasciectomy, palmar only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)
82.33	26170	Excision of tendon, palm, flexor, single, each
82.33	26180	Excision of tendon, finger, flexor
77.99	26185	Sesamoidectomy, thumb or finger
77.64	26210	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx of finger
77.89	26230	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); metacarpal
77.89	26235	proximal or middle phalanx of finger
77.89	26236	distal phalanx of finger

77.64		26260	Radical resection (ostectomy) for tumor, proximal or middle phalanx of finger
77.64		26261	with autograft (includes obtaining graft)
77.64		26262	Radical resection (ostectomy) for tumor, distal phalanx of finger

Repair, Revision, and/or Reconstruction

82.42 82.51 83.88	82.44 83.71	26350	Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon
82.43 83.71	82.51 83.88	26356	Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon
82.42 83.71	82.51 83.88	26357	secondary, each tendon
82.43 82.51	82.45	26418	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, hand or finger
83.88		26426	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues
82.84	83.88	26432	Extensor tendon repair, distal insertion ("mallet finger"), closed, splinting with or without percutaneous pinning
82.84	83.88	26433	Extensor tendon repair, distal insertion ("mallet finger"), open, primary or secondary repair; without graft
83.91		26440	Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon
83.91		26442	palm AND finger, each tendon
83.91		26445	Tenolysis, extensor tendon, dorsum of hand or finger; each tendon
82.11		26450	Tenotomy, flexor, single, palm, open, each

82.11		26455	Tenotomy, flexor, single, finger, open, each
82.11		26460	Tenotomy, extensor, hand or finger, single, open, each
80.44	80.94	26520	Capsulectomy or capsulotomy for contracture; metacarpophalangeal joint, single, each
80.44	80.94	26525	interphalangeal joint, single, each
77.34		26565	Osteotomy for correction of deformity; metacarpal
77.39		26567	phalanx of finger

Fracture and/or Dislocation

79.03	79.13	26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone
79.03	79.13	26605	with manipulation, each bone
79.03 79.14	79.13	26607	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone
78.54		26608	Percutaneous skeletal fixation of metacarpal fracture, each bone
79.03 79.74	79.13	26641	Closed treatment of carpometacarpal dislocation, thumb, with manipulation
79.03 79.74	79.13	26645	Closed treatment of carpometacarpal dislocation, thumb (Bennett fracture), with manipulation
78.14 79.13	78.54 79.73	26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation
79.74		26670	Closed treatment of carpometacarpal dislocation, thumb (Bennett fracture), single, with manipulation; without anesthesia

79.74		26675	requiring anesthesia
78.54	79.74	26676	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation
79.74		26700	Closed treatment of metacarpophalangeal dislocation, single; without anesthesia
79.74		26705	requiring anesthesia
78.54	79.74	26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation
79.04		26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
79.04		26725	with manipulation, with or without skin or skeleton traction, each
79.14		26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
79.04		26740	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; without manipulation, each
79.04		26742	with manipulation, each
79.04		26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each
79.04		26755	with manipulation, each
78.59		26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
79.70		26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia
79.70		26775	requiring anesthesia

78.59	79.74	26776	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation

Pelvis and Hip Joint
Including head and neck of femur

Incision

83.12	27000	Tenotomy, adductor of hip, subcutaneous, closed
83.12	27001	Tenotomy, adductor of hip, subcutaneous, open
80.15	27030	Arthrotomy, hip, for infection, with drainage
80.15	27033	Arthrotomy, hip, with exploration or removal of loose or foreign body

Excision

80.39	27050	Arthrotomy, with biopsy; sacroiliac joint
80.35	27052	hip joint
80.75	27054	Arthrotomy with synovectomy, hip joint

Introduction or Removal

81.92	88.32	27093	Injection procedure for hip arthrography; without anesthesia
81.92	88.32	27095	with anesthesia

Femur (Thigh Region) and Knee Joint
Including tibial plateaus.

Incision

83.03 83.09	83.03	27301	Incision and drainage of deep abscess, infected bursa, or hematoma, thigh or knee region

80.16		27310	Arthrotomy, knee, for infection, with exploration, drainage or removal of foreign body

Excision

80.36		27330	Arthrotomy, knee; with synovial biopsy only
80.16	80.36	27331	with joint exploration, with or without biopsy, with or without removal of loose or foreign bodies
80.6		27332	Arthrotomy, knee, with excision of semilunar cartilage (meniscectomy); medial OR lateral
80.6		27333	medial AND lateral
80.6		27334	Arthrotomy, knee, with synovectomy; anterior OR posterior
78.05 80.76	78.55	27335	anterior AND posterior including popliteal area
83.5		27340	Excision, prepatellar bursa
77.65	78.55	27355	Excision or curettage of bone cyst or benign tumor of femur

Introduction or Removal

81.92	88.32	27370	Injection procedure for knee arthrography
83.02 98.29	83.09	27372	Removal of foreign body, deep, thigh region or knee area

Repair, Revision, and/or Reconstruction

81.47		27403	Arthrotomy with open meniscus repair
80.46		27435	Capsulotomy, knee, posterior capsular release

Fracture and/or Dislocation

93.53	27500	Closed treatment of femoral shaft fracture, without manipulation
79.05 93.53	27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
79.45 93.46 93.53	27516	Closed treatment of distal femoral epiphyseal separation; with manipulation
79.09	27520	Closed treatment of patellar fracture, without manipulation
79.06 93.53	27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation
79.06 93.53	27538	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation
79.76	27550	Closed treatment of knee dislocation; without anesthesia
79.76	27552	requiring anesthesia
79.79	27560	Closed treatment of patellar dislocation; without anesthesia
79.79	27562	requiring anesthesia

Leg (Tibia and Fibula) and Ankle Joint

Incision

83.02 83.09	27603	Incision and drainage, leg or ankle; deep abscess or hematoma
83.11	27605	Tenotomy, Achilles tendon, subcutaneous ; local anesthesia
83.11	27606	general anesthesia
80.17	27610	Arthrotomy, ankle, for infection, with exploration, drainage or removal of foreign body

80.47	83.85	27612	Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening

Excision

80.17	80.37	27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body
80.77	83.42	27625	Arthrotomy, ankle, with synovectomy
83.31		27630	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion), leg and/or ankle
77.67		27635	Excision or curettage of bone cyst or benign tumor, tibia or fibula

Introduction or Removal

81.92		27648	Injection procedure for ankle arthrography

Repair, Revision, and/or Reconstruction

80.07		27704	Removal of ankle implant

Fracture and/or Dislocation

79.16	93.53	27750	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation
78.57		27756	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (e.g., pins or screws)
79.09		27760	Closed treatment of medial malleolus fracture; without manipulation
79.06		27780	Closed treatment of proximal fibula or shaft fracture; without manipulation
79.06		27781	with manipulation

79.06		27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation
79.06		27788	with manipulation
93.53		27808	Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation
79.09	93.53	27810	with manipulation
93.53		27816	Closed treatment of trimalleolar ankle fracture; without manipulation
79.09	93.53	27818	with manipulation
79.79		27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia
79.79		27831	requiring anesthesia
79.09	79.77	27840	Closed treatment of ankle dislocation; without anesthesia
79.09	79.77	27842	requiring anesthesia, with or without percutaneous skeletal fixation

Manipulation

79.79		27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)

Foot and Toes

Incision

80.18		28020	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
80.18		28022	metatarsophalangeal joint
80.18		28024	interphalangeal joint

	28035	Tarsal tunnel release (posterior tibial nerve decompression)

Excision

83.31 83.32 83.49	28045	deep, subfascial, intramuscular
80.38	28050	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint
80.38	28052	metatarsophalangeal joint
80.38	28054	interphalangeal joint
80.78	28070	Synovectomy; intertarsal or tarsometatarsal joint, each
80.78	28072	metatarsophalangeal joint, each
80.78	28086	Synovectomy, tendon sheath, foot, flexor
80.78	28088	extensor
80.78 80.88 83.31 83.39	28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot
80.78 80.88 83.31 83.39	28092	toes
77.68	28104	Excision of curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus
77.54 77.88	28110	Ostectomy, partial excision, fifth metatarsal head (bunionette)
77.88	28111	Ostectomy, complete excision; first metatarsal head
77.88	28112	other metatarsal head (second, third or fourth)
77.88	28113	fifth metatarsal head

77.88		28114	all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
77.88	77.98	28118	Ostectomy, calcaneus
77.88	83.09	28119	for spur, with or without plantar fascial release
77.88		28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis or talar bossing), talus or calcaneus
77.88		28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis or talar bossing), tarsal or metatarsal bone, except talus or calcaneus
77.89		28124	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis or dorsal bossing), phalanx of toe
77.89		28126	Resection, partial or complete, phalangeal base, single toe, each
77.98		28140	Metatarsectomy
77.89	77.99	28150	Phalangectomy of toe, single, each
77.89		28153	Resection, head of phalanx, toe
77.89		28160	Hemiphalangectomy or interphalangeal joint excision, toe, single, each

Introduction or Removal

86.05	98.28	28190	Removal of foreign body, foot, subcutaneous
83.03 98.28	83.09	28192	deep

Repair, Revision. and/or Reconstruction

83.91		28220	Tenolysis, flexor, foot; single
83.91		28222	multiple (through same incision)
83.91		28225	Tenolysis, extensor, foot, single
83.91		28226	multiple (through same incision)
83.13		28230	Tenotomy, open, flexor; foot, single or multiple
83.13		28232	toe, single
83.13		28234	Tenotomy, open, extensor, foot or toe
77.56		28285	Hammertoe operation, one toe (e.g., interphalangeal fusion, filleting, phalangectomy)
77.58		28286	Cock-up fifth toe operation with plastic skin closure (Ruiz-Mora type procedure)
77.51	77.88	28288	Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head
77.53	77.59	28292	Keller, McBride or Mayo type procedure
77.59		28293	resection of joint with implant
77.53		28294	with tendon transplants (Joplin type procedure)
77.51	77.59	28296	with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedure)
77.51		28297	Lapidus type procedure
77.59		28298	by phalanx ostectomy
77.59		28299	by other methods (e.g., double osteotomy)

78.58		28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation
78.58		28302	talus
77.28		28304	Ostectomy, midtarsal bones, other than calcaneus or talus;
77.28	77.38	28306	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal
78.28	78.38		
77.28	77.38	28307	first metatarsal with autograft
77.77	78.08		
78.28	78.38		
77.28	77.38	28308	other than first metatarsal
78.28	78.38		
77.29	77.38	28309	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)
77.29	78.29	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe
77.29	78.29	28312	other phalanges, any toe
83.09	83.75	28313	Reconstruction, angular deformity of toe (overlapping second toe, fifth toe, curly toes), soft tissue procedure only
77.98		28315	Sesamoidectomy, first toe
83.49		28340	Reconstruction, toe, macrodactyly, soft tissue resection

Fracture and/or Dislocation

93.53	93.54	28400	Closed treatment of calcaneal fracture; without manipulation
79.07	93.53	28405	with manipulation
93.54			

79.17		28406	Percutaneous skeletal fixation of calcaneal fracture; with manipulation
93.53		28430	Closed treatment of talus fracture; without manipulation
79.07	93.53	28435	with manipulation
79.17		28436	Percutaneous skeletal fixation of talus fracture, with manipulation
79.09		28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
79.09		28455	with manipulation, each
79.17		28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each
79.07 93.54	93.53	28470	Closed treatment of metatarsal fracture; without manipulation, each
79.07 93.54	93.53	28475	with manipulation, each
79.17		28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each
79.08 93.54	93.53	28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
79.09 93.54	93.53	28495	with manipulation
79.18		28496	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation
79.08	93.53	28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each

79.08 93.54	93.53	28515	with manipulation, each
79.08	79.18	28530	Closed treatment of sesamoid fracture
79.78		28540	Closed treatment of tarsal bone dislocation, other than talotarsal; without anesthesia
79.78		28545	requiring anesthesia
78.58	79.78	28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation
79.78		28570	Closed treatment of talotarsal joint dislocation, without anesthesia
79.78		28575	requiring anesthesia
78.58	79.77	28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation
79.78		28600	Closed treatment of tarsometatarsal joint dislocation; without anesthesia
79.78		28605	requiring anesthesia
78.58	79.78	28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation
79.78		28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
79.78		28635	requiring anesthesia
78.58	79.78	28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation
79.78		28660	Closed treatment of interphalangeal joint dislocation, without anesthesia

79.78	28665	requiring anesthesia
78.59 79.78	28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation

Arthroscopy

76.19 80.29 80.39	29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy
76.2 76.99	29804	Arthroscopy, temporomandibular joint, surgical
80.21 80.31	29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy
80.21	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
80.71	29820	synovectomy, partial
80.71	29821	synovectomy, complete
80.81	29822	debridement, limited
80.81	29823	debridement, extensive
80.41	29825	with lysis and resection of adhesions, with or without manipulation
81.82 81.83	29826	decompression of subacromial space with partial acromioplasty, with or without coracoacromial release
80.22 80.32	29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy
80.32	29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
80.72	29835	synovectomy, partial
80.72	29836	synovectomy, complete

80.82		29837	debridement, limited
80.82		29838	debridement, extensive
80.23	80.33	29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy
80.23		29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage
80.73		29844	synovectomy, partial
80.73		29845	synovectomy, complete
80.83	81.96	29846	excision and/or repair of triangular fibrocartilage and/or joint debridement
78.59		29847	internal fixation for fracture or instability
04.43		29848	with release of transverse carpal ligament
80.25	80.35	29860	Arthroscopy, hip, diagnostic with or without synovial biopsy
80.25		29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
80.85		29862	with debridement/shaving of articular cartilage (chrondroplasty), abrasion arthroplasty, and/or resection of labrum
80.75		29863	with synovectomy
80.26	80.36	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy
80.26		29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
80.96		29874	for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
80.76		29875	synovectomy, limited (e.g., plica or shelf resection)

80.76	29876	synovectomy, major, two or more compartments (e.g., medial or lateral)
80.86 81.47	29877	debridement/shaving of articular cartilage (chondroplasty)
81.47	29879	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling
80.6	29880	with meniscectomy (medial AND lateral, including any meniscal shaving)
80.6 81.42 81.43	29881	with meniscectomy (medial OR lateral, including any meniscal shaving)
81.47	29882	with meniscus repair (medial OR lateral)
81.47	29883	with meniscus repair (medial AND lateral)
80.26	29884	with lysis of adhesions, with or without manipulation
78.57 81.47	29885	drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
81.47	29886	drilling for intact osteochondritis dissecans lesion
78.57 81.47	29887	drilling for intact osteochondritis dissecans lesion with internal fixation
80.87	29891	Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect
83.14	29893	Endoscopic plantar fasciotomy
80.97	29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
80.77	29895	synovectomy, partial

80.87	29897	debridement, limited
80.87	29898	debridement, extensive

RESPIRATORY SYSTEM

Nose

Incision

21.1	30020	Drainage abscess or hematoma, nasal septum

Excision

21.31	30115	Excision, nasal polyp(s), extensive
21.31	30117	Excision or destruction, any method (including laser), intranasal lesion; internal approach
21.30	30118	external approach (lateral rhinotomy)
21.61 21.69	30130	Excision turbinate, partial or complete
21.61 21.69	30140	Submucous resection turbinate, partial or complete

Introduction

99.29	30200	Injection into turbinate(s), therapeutic
21.88	30220	Insertion, nasal septal prosthesis (button)

Removal of Foreign Body

98.12	30310	Removal foreign body, intranasal; requiring general anesthesia

Repair

21.86 21.87	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

21.83 21.87	21.86	30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
21.84	21.89	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
21.5	21.88	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
21.91		30560	Lysis intranasal synechia
21.88		30630	Repair nasal septal perforations

Destruction

21.61	21.69	30801	Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method; superficial
21.61	21.69	30802	intramural

Other Procedures

21.0 21.02	21.01 21.03	30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
21.62		30930	Fracture nasal turbinate(s), therapeutic

Accessory Sinuses

Incision

22.0 22.02	22.01	31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
22.0 22.02	22.01	31002	sphenoid sinus
22.2	22.39	31020	Sinusotomy, maxillary (antrotomy); intranasal
22.12	22.52	31050	Sinusotomy, sphenoid, with or without biopsy
21.31	22.12	31051	with mucosal stripping or removal of polyp(s)

22.52		
22.41	31070	Sinusotomy frontal; external, simple (trephine operation)
22.41	31075	transorbital, unilateral (for mucocele or osteoma, Lynch type)
22.53	31090	Sinusotomy combined, three or more sinuses

Excision

22.63	31200	Ethmoidectomy; intranasal, anterior
22.63	31201	intranasal, total
22.63	31205	extranasal, total

Endoscopy

21.21 22.19	31231	Nasal endoscopy, diagnostic, unilateral or bilateral
21.21 22.19	31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
22.19	31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoid face or cannulation of ostium)
21.30 21.31 21.32 22.11	31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement
21.0 21.03 21.07 21.09	31238	with control of epistaxis
22.63	31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
22.63	31255	with ethmoidectomy, total (anterior and posterior)
22.2	31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

22.2	22.62	31267	with removal of tissue from maxillary sinus
22.41	22.42	31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
22.52		31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
21.31	22.52	31288	with removal of tissue from the sphenoid sinus

Larynx

Endoscopy

31.42	31.48	31505	Laryngoscopy, indirect; diagnostic
31.43		31510	with biopsy
98.14		31511	with removal of foreign body
30.09		31512	with removal of lesion
31.48		31515	Laryngoscopy, direct, with or without tracheoscopy; for aspiration
31.42	31.48	31525	diagnostic, except newborn
31.42	31.48	31526	diagnostic, with operating microscope
98.14		31530	Laryngoscopy, direct, operative, with foreign body removal;
98.14		31531	with operative microscope
31.43	31.44	31535	Laryngoscopy, direct, operative, with biopsy
31.43	31.44	31536	with operative microscope
31.0		31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;
31.0		31571	with operating microscope

31.42	31.48	31575	Laryngoscopy, flexible fiberoptic; diagnostic
31.42	31.43	31576	with biopsy
98.14		31577	with removal of foreign body
30.09		31578	with removal of lesion
31.42	31.48	31579	Laryngoscopy, flexible or rigid fiberoptic; with stroboscopy

Trachea and Bronchi

Endoscopy

33.24		31622	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing
33.24		31625	with biopsy
33.27		31628	with transbronchial lung biopsy, with or without fluoroscopic guidance
33.24		31629	with transbronchial needle aspiration biopsy
31.64 33.91	31.99	31630	with tracheal or bronchial dilation or closed reduction of fracture
31.93	31.99	31631	with tracheal dilation and placement of tracheal stent
98.15		31635	with removal of foreign body
33.93	96.05	31645	with therapeutic aspiration of tracheobronchial tree, initial (e.g., drainage of lung abscess)
33.93	96.05	31646	with therapeutic aspiration of tracheobronchial tree, subsequent
87.31		31656	with injection of contrast material for segmental bronchography

31.48 87.07	33.29 87.32	31708	Instillation of contrast material for laryngography or bronchography, without catheterization
96.05		31720	Catheter aspiration; nasotracheal
		31830	Revision of tracheostomy scar

Lungs and Pleura

Endoscopy

34.21	32601	Thoracoscopy, diagnostic; lungs and pleural space, without biopsy

HEART AND PERICARDIUM

Pacemaker or Defibrillator

37.79	33222	Revision or relocation of skin pocket for pacemaker

Vascular Injection Procedures

Venous

39.92	36470	Injection of sclerosing solutions; single vein
39.92	36471	multiple veins, same leg
99.71 99.79	99.74 36520	Therapeutic apheresis (plasma and/or cell exchange)
86.06	36532	Removal of implantable intervenous infusion pump
86.09	36534	Revision of implantable venous access port, and/or subcutaneous reservoir
86.06	36535	Removal of implantable venous access port and/or subcutaneous reservoir

Ligation and Other Procedures

38.59	37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
38.59	37780	Ligation and division of short saphenous vein at saphenopopliteal junction

LYMPH NODES AND LYMPHATIC CHANNELS

Excision

40.11 40.21	38510	Biopsy or excision of lymph node(s); deep cervical node(s)
40.11 40.21	38520	deep cervical node(s) with excision scalene fat pad
40.11	38525	deep axillary node(s)
40.22	38530	internal mammary node(s)

Mediastinum and Diaphragm

Excision

34.3	39200	Excision of mediastinal cyst

Endoscopy

34.25	39400	Mediastinoscopy, with or without biopsy

DIGESTIVE SYSTEM

Lips

Excision

27.43	40500	Vermilionectomy (lip shave), with mucosal advancement

27.42	27.43	40510	Excision of lip; transverse wedge excision with primary closure
27.42	27.43	40520	V-excision with primary direct linear closure
27.42	27.43	40530	Resection of lip, more than one-fourth, without reconstruction

Repair

27.51	40650	Repair lip, full thickness; vermilion only
27.51	40652	up to half vertical height

Vestibule of Mouth

Excision, Destruction

27.41	40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)

Repair

27.52	40830	Closure of laceration, vestibule of mouth; 2.5 cm or less

Palate and Uvula

Incision

27.72	42140	Uvulectomy, excision of uvula
27.31	42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)

Repair

27.61	42180	Repair, laceration of palate; up to 2 cm

Salivary Gland and Ducts

Excision

26.32	42440	Excision of submandibular (submaxillary) gland
26.32	42450	Excision of sublingual gland

Other Procedures

26.42	42600	Closure salivary fistula
26.91	42650	Dilation salivary duct
26.91	42660	Dilation and catheterization of salivary duct, with or without injection
26.99	42665	Ligation salivary duct, intraoral

Pharynx, Adenoids and Tonsils

Excision, Destruction

29.39	42808	Excision or destruction of lesion of pharynx, any method
29.0 98.13	42809	Removal of foreign body from pharynx
28.4	42860	Excision of tonsil tags

Endoscopy

42.24	43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing
42.24	43202	with biopsy, single or multiple
98.02	43215	with removal of foreign body
42.33	43216	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
42.33	43217	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
42.83 42.84 42.92	43220	with balloon dilation (less than 30 mm diameter)
42.92	43226	with insertion of guide wire followed by dilation over guide wire
44.13	43234	Upper gastrointestinal endoscopy, simple primary examination (e.g.,

			with small diameter flexible endoscope)
45.16		43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing
45.16		43239	with biopsy, single or multiple
42.23	44.13	43241	with transendoscopic tube or catheter placement
42.33		43243	with injection sclerosis of esophageal and/or gastric varices
98.02	98.03	43247	with removal of foreign body
42.92		43248	with insertion of guide wire followed by dilation of esophagus over guide wire
42.92		43249	with balloon dilation of esophagus (less than 30 mm diameter)
42.33 45.30	43.41 45.33	43250	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
42.33 45.30	43.41 45.33	43251	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
42.33 45.30	43.41 45.34	43258	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
42.23 45.13	42.29 45.29	43259	with endoscopic ultrasound examination
51.10 52.19	51.19	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing
51.10 52.14	51.14 52.19	43261	with biopsy, single or multiple
51.85		43262	with sphincterotomy/papillotomy
51.88	52.94	43264	with endoscopic retrograde removal of stone(s) from biliary and/or pancreatic ducts

98.52	98.59	43265	with endoscopic retrograde destruction, lithotripsy of stone(s), any method
51.87	51.95	43269	with endoscopic retrograde removal of foreign body and/or change of tube or stent

Manipulation

42.92	43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes
42.92	43453	Dilation of esophagus, over guide wire
42.92	43456	Dilation of esophagus, by balloon or dilator, retrograde
42.92	43458	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia

Stomach

Excision

44.14	43600	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)

Introduction

43.11	43750	Percutaneous placement of gastrostomy tube
97.02	43760	Change of gastrostomy tube

Intestines (Except Rectum)

Excision

45.14	45.25 45.27	44100	Biopsy of intestine by capsule, tube, peroral (one or more specimens)
46.40		44340	Revision of colostomy; simple (release of superficial scar)

Endoscopy, Small Bowel and Stomal

45.13	45.14	44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum, diagnostic, with or without collection of specimen(s) by brushing or washing
45.14	45.16	44361	with biopsy, single or multiple
98.03		44363	with removal of foreign body
45.30		44364	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45.30		44365	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
		44366	with control of bleeding, any method
45.30		44369	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45.14		44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing
45.14	45.16	44377	with biopsy, single or multiple
44.43	45.13	44378	with control of bleeding, any method
45.12	45.14	44380	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing
45.14		44382	with biopsy, single or multiple
45.14		44385	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing
45.14		44386	with biopsy, single or multiple
45.23	45.25	44388	Colonoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing

45.23 45.25	44389	with biopsy, single or multiple
98.04	44390	with removal of foreign body
45.43	44391	with control of bleeding, any method
45.42 45.43	44392	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45.42 45.43	44393	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45.42 45.43	44394	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Rectum

Incision

48.0 49.91	45005	Incision and drainage of submucosal abscess, rectum
48.0 48.81	45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess

Excision

48.24 48.25 49.23	45100	Biopsy or anorectal wall, anal approach (e.g., congenital megacolon)
48.0 48.35	45170	Excision of rectal tumor, transanal approach
48.32 48.33 48.34	45190	Destruction of rectal tumor, any method (e.g., electrodesiccation) transanal approach

Endoscopy

48.23 48.24	45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing
96.22	45303	with dilation, any method

48.24		45305	with biopsy, single or multiple
98.04		45307	with removal of foreign body
48.32	48.36	45308	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
48.36		45309	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
48.32	48.36	45315	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45.42 48.33	45.43 49.36	45320	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (e.g., laser)
46.85	48.0	45321	with decompression of volvulus
45.24	45.25	45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing
45.25		45331	with biopsy, single or multiple
45.24	98.05	45332	with removal of foreign body
45.42	45.43	45333	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45.43		45334	with control of bleeding, any method
46.85		45337	with decompression of volvulus, any method
45.42	45.43	45338	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45.42 48.32	48.31	45339	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45.21 45.43	45.23	45355	Colonoscopy, rigid or flexible, transabdominal via colostomy, single or multiple

45.22 46.85	45.25	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression
45.23	98.04	45379	with removal of foreign body
45.25		45380	with biopsy, single or multiple
45.42		45382	with control of bleeding, any method
45.41	45.43	45383	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45.42	45.43	45384	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45.42	45.43	45385	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Manipulation

96.23		45905	Dilation of anal sphincter under anesthesia other than local
96.22		45910	Dilation of rectal stricture under anesthesia other than local
96.38	98.05	45915	Removal of fecal impaction or foreign body under anesthesia

Anus

Incision

49.01		46040	Incision and drainage of ischiorectal and/or perirectal abscess
49.02	49.93	46045	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia
49.01		46050	Incision and drainage, perianal abscess, superficial
49.01 49.11	49.02 49.12	46060	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton

49.51 49.59	49.52	46080	Sphincterotomy, anal, division of sphincter
49.47		46083	Incision of thrombosed hemorrhoid, external

Excision

49.46		46250	Hemorrhoidectomy, external, complete
49.46		46255	Hemorrhoidectomy, internal and external, simple;
49.12 49.46	49.31	46257	with fissurectomy
49.12	49.46	46258	with fistulectomy, with or without fissurectomy
49.12 49.46	49.31	46260	Hemorrhoidectomy, internal and external, complex or extensive;
49.12	49.46	46261	with fissurectomy
49.12 49.46	49.31	46262	with fistulectomy, with or without fissurectomy
49.11 49.73	49.12	46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
49.11 49.73	49.12	46275	submuscular
49.47		46320	Enucleation or excision of external thrombotic hemorrhoid

Endoscopy

49.23		46600	Anoscopy; diagnostic, with or without collection of specimen(s) by brushing or washing
96.23		46604	with dilation, any method
49.22	49.23	46606	with biopsy, single or multiple
49.21	98.05	46608	with removal of foreign body

49.31	46610	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
49.31	46611	with removal of single tumor, polyp, or other lesion by snare technique
49.31	46612	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
49.95	46614	with control of bleeding, any method
49.31	46615	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

Destruction

49.39	46922	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision
49.39	46924	Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
49.43 49.44 49.49	46934	Destruction of hemorrhoids, any method; internal
49.43 49.44 49.49	46935	external
49.43 49.44 49.49	46936	internal and external

Suture

49.45	46945	Ligation of internal hemorrhoids; single procedure
49.45	46946	multiple procedures

ABDOMEN, PERITONEUM, AND OMENTUM

Introduction, Revision, and/or Removal

97.05	47525	Change of percutaneous biliary drainage catheter
97.05	47530	Revision and/or reinsertion of transhepatic tube
97.82	49422	Removal of permanent intraperitoneal cannula or catheter

Repair

53.0 53.02 53.03 53.05 53.11 53.12 53.12 53.14 53.15 53.16 53.17	49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible
53.59 53.69	49570	Repair epigastric hernia (e.g., preperitoneal fat); reducible
53.41 53.49	49580	Repair umbilical hernia, under age 5 years; reducible

URINARY SYSTEM

Bladder

Introduction

55.92 55.96	50390	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous

Other Procedures

98.51	50590	Lithotripsy, extracorporeal shock wave

Ureter

Introduction

89.21	50686	Manometric studies through ureterostomy or indwelling ureteral catheter

Bladder

59.94	51705	Change of cystostomy tube; simple
59.94	51710	complicated
59.72	51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck

Endoscopy--Cystoscopy, Urethroscopy, Cystourethroscopy

57.32 58.22	52000	Cystourethroscopy
56.39 57.32 58.22 59.8	52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
56.33 56.39 57.32 59.8	52007	with brush biopsy of ureter and/or renal pelvis
57.32 87.99	52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

Transurethral Surgery

Urethra and Bladder

57.33	52204	Cystourethroscopy, with biopsy
57.49 59.31	52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
57.49	52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MINOR (less 0.5 cm) lesion(s) with or without biopsy

57.92		52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
57.92		52265	local anesthesia
57.32	58.5	52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
58.99		52282	Cystourethroscopy, with insertion of urethral stent
57.32 98.19	57.99	52310	Cystourethroscopy, with removal of foreign body calculus, or ureteral stent from urethra or bladder; simple
57.32 98.19	57.99	52315	complicated
57.99 98.19	59.95	52317	Lithopaxy; crushing or fragmentation of calculus by an means in bladder and removal of fragments; simple or small (less than 2.5 cm)

Ureter and Pelvis

56.0	57.32	52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
57.32	59.95	52325	with fragmentation of ureteral calculus (e.g., ultrasonic or electro-hydraulic technique)
57.32		52327	with subureteric injection of implant material
57.32		52330	with manipulation, without removal of ureteral calculus
55.22 57.32	56.31 58.22	52335	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method);
55.22 56.31	56.0	52336	with removal or manipulation of calculus (ureteral catheterization is included)
55.22 56.31	56.0	52337	with lithotripsy (ureteral catheterization is included)
55.22	56.31	52338	with biopsy and/or fulguration of lesion
60.95		52510	Transurethral balloon dilation of the prostatic urethra, any method

Urethra

Incision

58.1	53020	Meatotomy, cutting of meatus; except infant
58.1	53025	infant

Manipulation

58.6	53600	Dilation of urethral stricture by passage of sound or urethral dilator, male, initial
58.6	53601	subsequent
57.92 58.6	53605	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
58.6	53620	Dilation of urethral stricture by passage of filiform and follower, male; initial
58.6	53621	subsequent
58.6 96.49	53660	Dilation of female urethra including suppository and/or instillation; initial
58.6 96.49	53661	subsequent
58.6	53665	Dilation of female urethra, general or conduction (spinal) anesthesia

MALE GENITAL SYSTEM

Penis

Excision

64.96	54115	Removal foreign body from deep penile tissue (e.g., plastic implant)
64.0	54152	Circumcision, using clamp or other device; except newborn
64.0	54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; except newborn

Testis

Excision

62.12	54505	Biopsy of testis, incisional
62.0	54550	Exploration for undescended testis (inguinal or scrotal area)
63.01	54820	Exploration of epididymis, with or without biopsy

Tunica Vaginalis

61.19	55000	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication
61.2	55040	Excision of hydrocele; unilateral
61.2	55041	bilateral
61.2	55120	Removal of foreign body in scrotum

Vas Deferens

Incision

63.6	55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral
63.73	55250	Vasectomy, unilateral or bilateral, including postoperative semen examination(s)

Introduction

63.6 87.91 87.92 87.93 87.93 87.95	55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral
6371	55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral

FEMALE GENITAL SYSTEM

Laparoscopy/Peritoneoscopy/Hysteroscopy

54.24	49320	Laparoscopy, diagnostic
66.29	58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
66.22 66.29	58671	with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
65.11 66.91	49322	with aspiration (single or multiple)
68.12	58555	Hysteroscopy, diagnostic
68.16 68.29 69.09	58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
68.21	58559	with lysis of intrauterine adhesions (any method)
68.22	58560	with division or resection of intrauterine septum (any method)

Vulva, Perineum and Introitus

Incision

71.01	56441	Lysis of labial adhesions

Destruction

71.3	56515	extensive, any method

Excision

71.24	56740	Excision of Bartholin's gland or cyst

Vagina

Excision

70.8	57120	Colpocleisis (Le Fort type)
70.33	57135	Excision of vaginal cyst or tumor

Manipulation

96.16	57400	Dilation of vagina under anesthesia
70.29	57410	Pelvic examination under anesthesia
98.17	57415	Removal of impacted vaginal foreign body under anesthesia

Cervix Uteri

Excision

67.11 67.12 67.31 67.39	57500	Biopsy, single or multiple, or local excision of lesion, with or without fulguration
69.09	57505	Endocervical curettage (not done as part of a dilation and curettage)
67.32	57510	Cauterization of cervix; electro or thermal
67.33	57511	cryocautery, initial or repeat
67.39	57513	laser ablation
67.2 69.09	57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
67.2 67.32 69.09	57522	loop electrode excision
67.5	57700	Cerclage of uterine cervix, nonobstetrical

Manipulation

67.0	57800	Dilation of cervical canal, instrumental
69.09	57820	Dilation and curettage of cervical stump

Corpus Uteri

Excision

67.11 67.12 68.13 68.16	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method
69.09	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
68.19 87.82 87.83 87.84	58340	Catheterization and introduction of saline or contrast material for hysterosonography or hysterosalpingography

Oviduct

Incision

66.32	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
66.31 66.39	58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

Ovary

Incision

65.09 65.91 65.93	58800	Drainage of ovarian cyst(s), unilateral or bilateral; vaginal approach

Excision

65.12	58900	Biopsy of ovary, unilateral or bilateral

MATERNITY CARE AND DELIVERY

Incision

75.1	59000	Amniocentesis, any method
75.34	59020	Fetal contraction stress test
75.34	59025	Fetal non-stress test

NERVOUS SYSTEM

Spine and Spinal Cord

Injection, Drainage, or Aspiration

03.99	62268	Percutaneous aspiration, spinal cord cyst or syrinx
03.32	62269	Biopsy of spinal cord, percutaneous needle
03.31	62270	Spinal puncture, lumbar, diagnostic
03.31	62272	Spinal puncture, therapeutic, for drainage of spinal fluid (by needle or catheter)
03.92 87.21	62284	Injection procedure for myelography and/or computerized axial tomography, spinal (other than C1-C2 and posterior fossa)
05.9	62287	Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar
03.92 87.24	62290	Injection procedure for diskography, each level; lumber
03.92	62291	cervical
	62365	Removal of subcutaneous reservoir pump, previously implanted for intrathecal or epidural infusion

Somatic Nerves

Excision

04.07		64774	Excision of neuroma; cutaneous nerve, surgically identifiable
04.07		64776	digital nerve, one or both, same digit
04.07		64778	digital nerve, each additional digit
04.07		64782	hand or foot, except digital nerve
04.07		64783	hand or foot, each additional nerve, except same digit
04.07		64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve
04.11	04.19	64795	Biopsy of nerve

EYE AND OCULAR ADNEXA

Eyeball

Secondary Implant(s) Procedure

16.71	65175	Removal of ocular implant

Anterior Segment

Cornea

11.22	65410	Biopsy of cornea

Excision

11.31	11.39	65420	Excision or transposition of pterygium; without graft

Removal or Destruction

11.21		65430	Scraping of cornea, diagnostic, for smear and/or culture
11.31	11.41 11.49	65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)

11.31 11.49	11.41	65436	with application of chelating agent (e.g., EDTA)
11.42 11.49	11.43	65450	Destruction of lesion of cornea by cryotherapy, photocoagulation or thermocauterization

Anterior Sclera

Excision

12.84	66130	Excision of lesion, sclera

Lens

Incision

13.64 13.66	66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
13.64	66821	laser surgery (e.g., YAG laser) (one or more stages)

Removal Cataract

13.65 13.8	66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
13.70	66986	Exchange of intraocular lens
14.9	67027	Implantation or replacement of intravitreal drug delivery system (e.g., ganciclovir implant), includes concomitant removal of vitreous
14.6	67120	Removal of implanted material, posterior segment; extraocular
14.6	67121	intraocular

Eyelids

Repair (Brow Ptosis, Blepharoptosis, Lid Retraction, Ectropion, Entropion)

08.36	08.59	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
08.31		67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
08.32		67902	frontalis muscle technique with fascial sling (includes obtaining fascia)
08.42		67914	Repair of ectropion; suture
08.41		67915	thermocauterization
08.43		67916	blepharoplasty, excision tarsal wedge
08.44	08.49	67917	blepharoplasty, extensive (e.g., Kuhnt-Szymanowski or tarsal strip operations)
08.42		67921	Repair of entropion; suture
08.41		67922	thermocauterization
08.43		67923	blepharoplasty, excision tarsal wedge
08.44	08.49	67924	blepharoplasty, extensive (e.g., Wheeler operation)
08.99		67938	Removal of embedded foreign body, eyelid

Reconstruction

08.59	67950	Canthoplasty

Conjunctiva

Incision and Drainage

10.1	68040	Expression of conjunctival follicles (e.g., for trachoma)

Excision and/or Destruction

10.21	68100	Biopsy of conjunctiva
10.31	68110	Excision of lesion, conjunctiva; up to 1 cm

Lacrimal System

Probing and/or Related Procedures

09.43	68811	requiring general anesthesia
09.43 09.44	68815	with insertion of tube or stent
09.19 87.05	68850	Injection of contrast medium for dacryocystography

Auditory System

Removal of Foreign Body

18.9 98.11	69205	Removal of foreign body from external auditory canal; with general anesthesia

Repair

18.5	69300	Otoplasty, protruding ear, with or without size reduction

Incision

20.09	69420	Myringotomy including aspiration and/or eustachian tube inflation
20.09	69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
20.1	69424	Ventilating tube removal when originally inserted by another physician
20.01 20.23	69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia

20.01	69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia

Excision

20.51	69540	Excision aural polyp

Repair

19.4 19.52	69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch
19.4	69620	Myringoplasty (surgery confined to drumhead and donor area)

RADIOLOGY

87.21	72240	Myelography, cervical, radiological supervision and interpretation
87.21	72255	Myelography, thoracic, radiological supervision and interpretation
87.21	72265	Myelography, lumbosacral, radiological supervision and interpretation
87.21	72270	Myelography, entire spinal canal, radiological supervision and interpretation
87.21	72285	Diskography, cervical, radiological supervision and interpretation
87.22	72295	Diskography, lumbar, radiological supervision and interpretation
88.92	75552	Cardiac magnetic resonance imaging for morphology; without contrast material
88.92	75553	with contrast material

MEDICINE

Peritoneal Dialysis

54.98	90945	Dialysis procedure other than hemodialysis (e.g., peritoneal, hemofiltration), with single physician evaluation

54.98	90947	Dialysis procedure other than hemodialysis (e.g., peritoneal, hemofiltration), requiring repeated evaluations, with or without substantial revision of dialysis prescription

Special Ophthalmological Services

95.04	92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
95.04	92019	limited

Special Otorhinolaryngologic Services

18.19	92502	Otolaryngologic examination under general anesthesia
29.11	92511	Nasopharyngoscopy with endoscope

Procedure Codes Requiring Pre-Authorization
By DMAS Medical Support

CPT code	Code Description
	Anesthesia
00402	Anesthesia for procedures on anterior integumentary system of chest, including subcutaneous tissue; reconstructive procedures on breast (e.g., reduction or augmentation mammoplasty, muscle flaps)
00938	Anesthesia for procedures on male external genitalia; insertion of penile prosthesis (perineal approach)
	Integumentary System
11970	Replacement of tissue expander with permanent prosthesis
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty
15832	thigh
15833	leg
15834	hip
15835	buttock
15836	arm
15837	forearm or hand
15838	submental fat pad
15839	other area
19140	Mastectomy for gynecomastia
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19350 Nipple/areola reconstruction

19355 Correction of inverted nipple

19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

19361 Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant

19364 Breast reconstruction with free flap

19366 Breast reconstruction with other technique

19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;

19368 with microvascular anastomosis (supercharging)

19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

19380 Revision of reconstructed breast

19396 Preparation of moulage for custom breast implant

Musculoskeletal System

20974 Electrical stimulation to aid bone healing; noninvasive (nonoperative)

20975 invasive (operative)

21121 Genioplasty; sliding osteotomy, single piece

21122 sliding osteotomies, two or more osteotomies (e.g., wedge resection or bone wedge reversal for asymmetrical chin)

21123 sliding, augmentation with interpositional bone graft (including obtaining autografts)

21125 Augmentation, mandibular body or angle; prosthetic material

21127 with bone graft, onlay or interpositional (including obtaining autografts)

21240 Arthroplasty, temporomandibular joint, with or without autograft (including obtaining graft)

21242 Arthroplasty, temporomandibular joint, with allograft

21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement

Respiratory System:

30220 Insertion, nasal septal prosthesis (button)

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410 complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

30420 including major septal repair

30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

30435 intermediate revision (bony work with osteotomies)

30450 major revision (nasal tip work and osteotomies)

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft

Cardiovascular System:

33970 Insertion of intra-aortic balloon assist device through the femoral artery, open approach

33973 Insertion of intra-aortic balloon assist device through the ascending aorta

33975 Implantation of ventricular assist device; single ventricle support

33976 biventricular support

Digestive System

41820 Gingivectomy, excision gingiva, each quadrant

41821 Operculectomy, excision pericoronal tissues

41828 Excision of hyperplastic alveolar mucosa, each quadrant (specify)

41830 Alveolectomy, including curettage of osteitis or sequestrectomy

41870 Periodontal mucosal grafting

41872 Gingivoplasty, each quadrant (specify)

41874 Alveoloplasty, each quadrant (specify)

42145 Palatopharyngoplasty (e.g., uvulopalatopharynoplasty, uvulopharyngoplasty)
note: excluding those done for congenital malformation

42280 Maxillary impression for palatal prosthesis

note: excluding those done for congenital malformation

43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty

43843 other than vertical-banded gastroplasty

43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy

43847 with small bowel reconstruction to limit absorption

43848 Revision of gastric restrictive procedure for morbid obesity

46750 Sphincteroplasty, anal, for incontinence or prolapse; adult

46751 child

Urinary System

53445 Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir

53447 Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff

53449 Surgical correction of hydraulic abnormality of inflatable sphincter device

Male Genital System:

54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)

54401 inflatable (self-contained)

54402 Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis

54405 Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir

54407 Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders

54409 Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or reservoir and/or cylinders

55175 Scrotoplasty; simple

55180 complicated

Eye and Ocular System

67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
67902	frontalis muscle technique with fascial sling (includes obtaining fascia)
67903	(tarso)levator resection or advancement, internal approach
67904	(tarso)levator resection or advancement, external approach
67906	superior rectus technique with fascial sling (includes obtaining graft)
67908	conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

Auditory System

69300	Otoplasty, protruding ear, with or without size reduction
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone
69930	Cochlear device implantation , with or without mastoidectomy

Contact Lens Services:

These codes are limited to Medicaid recipients under the age of 21 years of age

92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92311	corneal lens for aphakia, one eye
92312	corneal lens for aphakia, both eyes
92313	corneoscleral lens
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia
92315	corneal lens for aphakia, one eye
92316	corneal lens for aphakia, both eyes
92317	corneoscleral lens
92395	Supply of permanent prosthesis for aphakia; spectacles
92396	contact lenses

Orthotic Procedures:

All HCPCS codes for **orthotic procedures** must be pre-authorized. The range for these codes is L0100 through L4398.

Prosthetic Procedures:

All HCPS codes for **prosthetic procedures** must be pre-authorized. The range for these codes is L5000 through L8499

L8500 Artificial larynx

Transplant Procedures:

All **organ transplants** must be preauthorized except for corneal.

TRANSPLANT PROCEDURE CODE:

From CPT' 1994-98:

ANESTHESIA:

00580 Anesthesia for heart transplant or heart/lung transplant

00796 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)

00862 Anesthesia for extraperitoneal procedures on lower abdomen, including urinary tract; renal procedures, including upper 1/3 of ureter, or donor nephrectomy

00868 renal transplant (recipient)

01990 Physiological support for harvesting of organ(s) from brain-dead patient

LUNG:

32850 Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)

32851 Lung transplant, single, without cardiopulmonary bypass

32852 with cardiopulmonary bypass

32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass

32854 with cardiopulmonary bypass

HEART:

33930	Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy
33940	Donor cardiectomy, with preparation and maintenance of allograft
33945	Heart transplant, with or without recipient cardiectomy

BONE MARROW:

38230	Bone marrow harvesting for transplantation
38231	Blood-derived peripheral stem cell harvesting for transplantation, per collection
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241	autologous

LIVER:

47133	Donor hepatectomy, with preparation and maintenance of allograft; from cadaver donor
47134	partial, from living donor
47135	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age
47136	heterotopic, partial or whole, from cadaver or living donor, any age

PANCREAS:

48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islets
48550	Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation
48554	Transplantation of pancreatic allograft

KIDNEY:

50300	Donor nephrectomy, with preparation and maintenance of allograft; from cadaver donor, unilateral or bilateral
50320	from living donor
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
50365	with recipient nephrectomy
50380	Renal autotransplantation, reimplantation of kidney

PARATHYROID:

60512	Parathyroid autotransplantation

From ICD-9 Procedure Codes:

THYROID:

06.94	Thyroid tissue reimplantation

PARATHYROID:

06.95	Parathyroid tissue reimplantation

THYMUS:

07.94	Transplantation of thymus

LUNG:

33.5	Lung transplant
33.50	Lung transplantation, not otherwise specified
33.51	Unilateral lung transplantation
33.52	Bilateral lung transplantation
33.6	Combined heart-lung transplantation

HEART:

33.6 Combined heart-lung transplantation

37.5 Heart transplantation

BONE MARROW:

41.0 Bone marrow or hematopoietic stem cell transplant

41.00 Bone marrow transplant, not otherwise specified

41.01 Autologous bone marrow transplant

41.02 Allogeneic bone marrow transplant with purging

41.03 Allogeneic bone marrow transplant without purging

41.04 Autologous hematopoietic stem cell transplant

41.05 Allogeneic hematopoietic stem cell transplant

41.06 Cord blood stem cell transplant

41.91 Aspiration of bone marrow from donor for transplant

SPLEEN:

41.94 Transplantation of spleen

LIVER:

50.5 Liver transplant

50.51 Auxiliary liver transplant

50.59 Other liver transplant of liver

PANCREAS:

52.8 Transplant of pancreas

52.80 Pancreatic transplant, not otherwise specified

52.81 Reimplantation of pancreatic tissue

52.82 Homotransplant of pancreas

52.83 Heterotransplant of pancreas

52.84 Autotransplantation of cells of Islets of Langerhans

52.85 Allotransplantation of cells of Islets of Langerhans

52.86 Transplantation of cells of Islets of Langerhans, not otherwise specified

KIDNEY:

55.6 Transplant of kidney

55.61 Renal autotransplantation

55.69 Other kidney transplantation

55.97 Implantation or replacement of mechanical kidney

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

____ See one time only for _____

____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY